but also by ERISA plans, and, in particular, claims involving an ERISA plan's assertions of purported reimbursement and subrogation rights. *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst,* 102 F.3d 1368, 1373 (5th Cir. 1996).

A two step analysis is typically utilized. *Gooselink,* 272 F.3d at 726; *Threadgill,* 145 F.3d at 292; *Wildbur,* 974 F.2d at 631; *Bourgeois,* 308 F. Supp. 2d at 763. First, a court determines whether the administrator gave the plan the legally correct interpretation. *Id.* To determine whether the administrator's interpretation was legally correct, a court considers:

1. whether the administrator has given the plan a uniform construction;
2. whether the administrator's interpretation is consistent with the fair reading of the plan; and
3. whether different interpretations of the plan will result in unanticipated costs.

Id.

If a court concludes that the administrator did not give a legally correct interpretation, a court next determines whether the interpretation constitutes an abuse of discretion. *Id.* In making that analysis, three factors are particularly important:

1. the internal consistency of the plan under the administrator's interpretation;
2. any relevant regulations; and
3. the factual background of the determination and inferences of lack of good faith.

Id.

These three factors, however, are non-exclusive and do not apply to every case. *Gooselink,* 272 F.3d at 726-27; *Threadgill,* 145 F.3d at 292 n. 12; *Duhon v. Texaco, Inc.,* 15 F.3d 1302, 1307-08 & n. 3 (5th Cir. 1994); *Bourgeois,* 308 F. Supp. 2d at 763-64. Consequently, when an administrator interprets a plan in a way that directly contradicts the plain meaning of the plan language, the administrator abuses his discretion even if there is neither evidence of bad faith nor a violation of any pertinent administrative regulations. *Gooselink,* 272 F.3d at 727.

Moreover, other factors, such as conflict of interest, should be considered when applicable. *See Vega v. National Life Ins. Svcs.,* 188 F.3d 287, 297 (5th Cir. 1999); *Bourgeois,* 308 F. Supp. 2d at 763-64. The greater the evidence of conflict of interest, the less deferential the abuse of discretion standard will be. *Id.*

MHHS' attempt to have this Court apply a different standard under the auspices of *Firestone Tire & Rubber Co. v. Bruch* is erroneous. *Firestone* did not specifically address the abuse of discretion standard, but instead concerned the *de novo* standard of review in the context of denial of benefits and the interpretation of the term "benefit." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108 (1989). In *Firestone*, the Court discussed some similarities of trust terminology with ERISA such as the terms beneficiary, fiduciary, trustee, and fiduciary duties. *Id.* at 110. The Court, however, did not adopt trust principles across the board. Instead, the Court commented that it was guided by principles of trust law. *Id.* at 111.

Moreover, the standard that petitioner would have this Court adopt is not, as of this date, effective. Petitioner's authority of the RESTATEMENT (THIRD) OF TRUSTS

§ 87 is a tentative draft. Petitioner's request to ignore years of precedent concerning the abuse of discretion standard and adopt the standard in the RESTATEMENT (THIRD) OF TRUSTS should clearly be rejected.

The bottom line is petitioner demands the carte blanche right to do whatever it wants without any regard for the individual rights of a participant's grieving widow. Carol Pittman tragically had her husband taken from her, and petitioner claims it can also take her individual cause of action for this loss. Common sense, and public policy dictate otherwise.

2. The Plan Language was Consistent

The pertinent provisions of the Plan are as follows:

8.2. *Death or Dismemberment; Schedule of Benefits.*

> In the event of the Death of an Eligible Employee, any Death Benefits payable hereunder shall be paid to **the personal representative of the estate** of the deceased Eligible Employee after the Administrative Committee receives appropriate directions. In the event that no administration is had on the Eligible Employee's estate, any Death Benefits payable hereunder shall be paid to the Eligible Employee's heirs at law, as such heirs are determined by the Administrative Committee in its discretion. Each recipient of a Death Benefit may be required to sign an appropriate release of claims under the Plan as determined by the Administrative Committee.

11.1. *Plan Right of Subrogation.* In the event of any Benefit payment made under the Plan to or on behalf of any Employee, the Plan shall, **to the**

extent of such payments be subrogated to all the rights of recovery and other rights of the **Employee** arising out of any claim or cause of action which may accrue. . . . Employee, by participation in the Plan agrees **that his estate, and the legal representative of his estate** shall likewise be obligated and that the Plan shall be fully subrogated to any recovery or right of recovery that **the estate** may have against any third party. . . .

The employee, or the legal representative or beneficiaries of Employee shall notify the Plan Administrator of any claim or lawsuit against a third party or insurance carrier within thirty (30) days of the date that the claim is made or the lawsuit is filed. The Plan Administrator, on behalf of the Plan, also has the right to pursue any action to enforce its subrogation rights against a third party.

11.2. *Employee's Agreement To Subrogation.* Employee, on behalf of himself **and each beneficiary of a payment made on Employee's behalf**, by accepting Benefits under the Plan, consents and agrees (i) that the Plan **shall be promptly reimbursed** for any payments made to or on the Employee's behalf under the Plan out of any monies recovered as the result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement. . . . Furthermore, **Employee and said beneficiaries** promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, reimbursement agreements and other instruments as the Plan Administrator may require to facilitate enforcement of the Plan's subrogation

> rights, and not to prejudice, or in any way detrimentally affect, such rights.
>
> 11.3 *Limitation to Plan's Subrogation Rights.* The Plan's subrogation rights (a) shall extend only to the recovery by the Plan of (i) the Benefits that it has paid or will pay to or on behalf of the Employee and (ii) the cost of prosecuting the claim including attorney's fees and court and collection costs and (b) shall fully apply even if the Participant or beneficiary thereof has only received a partial recovery from a third party.

(Emphasis added) (App., 101 at 133-34, 143, 144-45).

According to the Administrative Committee, pursuant to §§ 11.1 and 11.2 of the Plan, the Administrative Committee had the right to require Carol Pittman to assign **all** of her claims to the Plan, and the Plan had the right to control the prosecution of any claims she or the estate of John Pittman may have against third parties. As the Fifth Circuit held, this language means only that the Pittman Estate, via Pittman as the Estate Representative, is subject to MHHS' subrogation rights. The language does not mean that Carol Pittman must surrender the wrongful death claims she independently possesses as John Pittman, Jr.'s wife simply because she also served as the Executrix of the Pittman Estate.

MHHS should not be allowed to profit by now claiming there is an inconsistency in a document it drafted. The Texas Wrongful Death Statute and Survival Statute set forth the relevant causes of action. *See* TEX. CIV. PRAC. & REM. CODE §§ 71.002-71.004 & 71.021(b) (Vernon 2005). Even petitioner concedes that this statute, like almost all wrongful death statutes, provides that an estate can never

have a wrongful death claim. This Court should not allow MHHS to benefit from its own mistake.

III. THE FIFTH CIRCUIT'S OPINION DOES NOT EMASCULATE CONGRESS' RULINGS PROTECTING CERTAIN POLICIES

As opposed to petitioner's assertion, the Fifth Circuit's opinion does not prohibit a plan administrator from exercising discretion. Instead, it requires a plan administrator not to abuse his discretion. (App., 1). As explained *supra*, this is the well-reasoned standard established many years ago. Adopting petitioner's position would allow a plan administrator to make a decision without any basis when the plan has some inconsistent language. This contention is untenable.

IV. THE FIFTH CIRCUIT'S OPINION DOES NOT THREATEN THE CONTINUED EFFICACY OF CONGRESS' ERISA POLICY AND THIS COURT'S RULINGS PROTECTING THAT POLICY

MHHS contends that it should be allowed to usurp Carol Pittman's individual claim under the guise that it is necessary to ensure that plan assets are soundly managed for the benefit of current and future beneficiaries. MHHS further alleges that it should, as a practical matter, be able to steal Carol Pittman's wrongful death claim to accurately assess the future benefits expenses MHHS will be required to pay. This position is absurd. Instead of individual participants seeking to exploit ambiguities in a plan, it is MHHS who is attempting to exploit individual rights. In this case, most importantly, these rights do not belong to a participant or beneficiary. The rights belong to

Carol Pittman individually. MHHS obviously should not be allowed to fleece these individual rights.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

LAWRENCE D. THOMPSON
TBN: 19930000
PHILLIP C. SUMMERS
TBN: 19506600
SHANNON L. RANKIN
TBN: 16546250
LORANCE & THOMPSON, P.C.
2900 North Loop West, Suite 500
Houston, Texas 77092
(713) 868-5560

Counsel for Respondent Carol Ann Pittman, also known as Carol Ann Peterson, Independent Executrix of the Estate of John Linwood Pittman, Jr. Deceased and Individually and as Beneficiary of John Linwood Pittman, Jr.

APPENDIX

Page

Circuit Court Decision.....App. 1

Order of District Court Denying Pittman's Motion for Partial Summary Judgment.....App. 16

Order of District Court Granting MHHS Motion for Partial Summary Judgment.....App. 29

Agreed Final Judgment of Probate Court of Galveston.....App. 44

Denial of Petition for Rehearing En Banc.....App. 48

29 U.S.C. §1002.....App. 50

Tex. Civ. Prac. & Rem. Code § 71.001-71.004.....App. 72

Tex. Civ Prac. & Rem. Code § 71.021.....App 76

Restatement (Third) of Trusts (Tentative Draft) § 87.....App. 77

Restatement (Second) of Trusts § 183.....App. 100

MHHS ERISA Plan.....App. 101

MJHS Letter Re: Decision of Administrative Committee.....App. 163

H.R. 93-533; 93d Cong.....App. 166

No. 04-20349
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

CHARLES ATTEBERRY, SR, ET AL,
Plaintiffs

v.

MEMORIAL-HERMANN HEALTHCARE SYSTEMS,
On Behalf and for the Benefit of The Estates,
Heirs, Devisees, Legatees, Spouses, Children
and/or Parents of Charles Atteberry, Jr.,
Plaintiffs-Appellees

v.

MEMORIAL-HERMANN HEALTHCARE SYSTEM;
MEMORIAL-HERMANN HOSPITAL SYSTEM,
Plaintiffs-Appellants-Appellees

v.

BEN ETHRIDGE,
Intervenor-Plaintiff-Appellee

v.

DALINDA SHELTON; CAROL ANN PITTMAN,
also known as Carol Ann Peterson, Independent
Executrix of the Estate of John Linwood Pittman, Jr.,
Deceased and Individually as Beneficiary of
John Linwood Pittman, Jr.,
Intervenor-Plaintiffs-Appellants

v.

EUROCOPTER DEUTSCHLAND, GMBH, ET AL,
Defendants

April 1, 2005, Filed

JUDGES: Before GARWOOD, BENAVIDES and STEWART, Circuit Judges.

OPINION BY: BENAVIDES

OPINION: BENAVIDES, Circuit Judge:

I. INTRODUCTION

This action arises from the crash of a Life Flight helicopter owned and operated by Memorial-Hermann Healthcare System and Memorial-Hermann Hospital System (collectively "MHHS"). All three MHHS employees aboard the helicopter – Charles Atteberry, Jr., John Pittman, Jr., and Silvia Lynn Ethridge – perished in the crash. At the time of their deaths, the employees were covered by MHHS' ERISA Occupational Benefits Plan (the "Occupational Benefits Plan") which essentially provided death benefits of $1,000,000 to the estate of the deceased employee or, in the absence of a will, to the employee's heirs at law.

This appeal involves the claims of three separate appellants, Dalinda Shelton ("Shelton"), MHHS, and Carol Pittman ("Pittman"). Each of the disputes centers on the scope and extent of MHHS' claimed subrogation rights following the payment of death benefits pursuant to MHHS' Occupational Benefits Plan. More specifically, Shelton appeals the district court's grant of summary judgment against her and its conclusion that MHHS' subrogation right gives MHHS the right to control the prosecution and settlement of the claims of the Estate of Silvia Lynn Ethridge (the "Ethridge Estate"). MHHS appeals the district court's denial of its motion for summary judgment with respect to Ben Ethridge and its conclusion that MHHS is not subrogated to Ben Ethridge's wrongful death claim arising from the death of his daughter Silvia Ethridge. Pittman appeals the district court's

grant of partial summary judgment against her – as well as its subsequent denial of her motion for partial summary judgment against MHHS – and its conclusion that MHHS is subrogated to her claims, both as an individual and as the independent executrix of the Estate of John Linwood Pittman, Jr. (the "Pittman Estate").

Having reviewed the record and considered the briefs and arguments on appeal, we uphold the district court's grant of summary judgment against Shelton and its denial of MHHS' motion for summary judgment with respect to Ben Ethridge. However, we reverse the district court's grant of summary judgment against Pittman in her individual capacity.

II. STANDARD OF REVIEW

The parties agree that MHHS' ERISA Occupational Benefits Plan Administrative Committee (the "Administrative Committee") had discretionary and final authority to interpret MHHS' Occupational Benefits Plan and make all necessary factual findings. When a plan administrator has such discretionary authority, this Court applies an abuse of discretion standard. *Pickrom v. Belger Cartage Serv., Inc.*, 57 F.3d 468, 471 (5th Cir. 1995). This Court reviews *de novo* the district court's holdings regarding whether a plan administrator has abused its discretion. *Threadgill v. Prudential Sec. Group, Inc.*, 145 F.3d 286, 292 (5th Cir. 1998).

III. DISCUSSION

A. Dalinda Shelton and Ben Ethridge

1. Factual and procedural history

On December 23, 1999, MHHS paid a death benefit under its Occupational Benefits Plan in the amount of $1,050,816 to the Ethridge Estate through Dalinda Shelton; Shelton is Silvia Ethridge's same-sex domestic partner, the personal representative and independent executrix of the Ethridge Estate, and the principal beneficiary under Silvia Ethridge's will. Payment of the death benefit to the estate representative is consistent with Article 8.2 of MHHS' Occupational Benefits Plan which states that "in the event of the Death of an Eligible Employee, any Death Benefits payable hereunder shall be paid to the personal representative of the estate of the deceased Eligible Employee after the Administrative Committee receives appropriate directions."

At the time the death benefit was paid, Shelton and the Occupational Benefits Plan Administrator for MHHS entered into an Acknowledgment of Receipt of Benefits, Subrogation Rights and Confidentiality Agreement (the "Agreement"). As part of the Agreement, Shelton recognized that she received funds from MHHS' Occupational Benefits Plan and acknowledged that MHHS was subrogated to the Ethridge Estate's claims and causes of action. The Administrative Committee subsequently determined that MHHS' subrogation rights gave it the right to pursue and settle the Ethridge Estate's claims without the participation of Shelton as the Ethridge Estate representative.

Ben Ethridge, for his part, denies receiving Occupational Benefits Plan death benefits. In his deposition

testimony, Ben Ethridge acknowledged receipt of a share of the Occupational Benefits Plan death benefit, but stated that he received that money not from the Occupational Benefits Plan, but as a gift from Shelton. Although Ben Ethridge did not receive Occupational Benefits Plan death benefits, he did receive other insurance proceeds resulting from his daughter's death; those proceeds were paid to him through separate insurance policies that are different from the Occupational Benefits Plan that is at the heart of the instant dispute. Specifically, Ben Ethridge received life insurance and accidental death and dismemberment insurance proceeds pursuant to a Beneficiary Designation Form, on which Silvia Ethridge designated both Ben Ethridge and Dalinda Shelton as her designated beneficiaries. At oral argument, it was conceded by MHHS that while the Beneficiary Designation Form determined how the life insurance and accidental death and dismemberment insurance proceeds were to be paid out in the event of Silvia Ethridge's death, it did not set forth how the death benefit under MHHS' Occupational Benefits Plan was to be disbursed.

The Administrative Committee determined that the Beneficiary Designation Form governed the disbursement of the death benefit under MHHS' Occupational Benefits Plan and that Ben Ethridge was a designated beneficiary who received Occupational Benefits Plan monies, albeit indirectly from Shelton. The Administrative Committee concluded that because Ben Ethridge was a beneficiary of Occupational Benefits Plan death benefits, his wrongful death cause of action was subrogated to MHHS, which could then sue third parties on Ben Ethridge's behalf.

MHHS filed suit against the third-party helicopter manufacturer on behalf of, *inter alios*, Ben Ethridge and

the Ethridge Estate. The district court subsequently permitted Shelton and Ben Ethridge to intervene in the action. Shelton claimed that as executrix of the Ethridge Estate, she had the right to control the prosecution and settlement of Silvia Ethridge's survival action. Ben Ethridge contended that his wrongful death cause of action was not subrogated to MHHS because he was not a recipient of Occupational Benefits Plan death benefits and that, therefore, MHHS could not sue the helicopter manufacturer on his behalf.

MHHS moved for summary judgment against Shelton, as executrix and beneficiary, and against Ben Ethridge. The district court granted MHHS' motion for summary judgment with respect to Shelton and concluded that MHHS, as subrogee, has the authority to prosecute and settle the claims of the Ethridge Estate without the consent or participation of the Ethridge Estate representative. The district court denied MHHS' motion for summary judgment with respect to Ben Ethridge and concluded that Ben Ethridge's claims were not subrogated to MHHS because he had not received Occupational Benefits Plan death benefits. Shelton and MHHS subsequently appealed the judgment of the district court.

2. Shelton's claims

Because it is undisputed that MHHS is subrogated to the Ethridge Estate's causes of action, the sole issue of contention between Shelton and MHHS is the meaning of the term "subrogation" as used in the Occupational Benefits Plan. Shelton contends that the Administrative Committee's interpretation of the meaning of subrogation amounts to an abuse of discretion because MHHS' subrogation rights do

not allow MHHS the right to exclusively control the Ethridge Estate's causes of action without the consent or participation of the Ethridge Estate representative.

We conclude that the Administrative Committee's interpretation of the meaning of subrogation is legally correct under both an ordinary meaning analysis and the three-part test this Court employs to determine the legal correctness of an ERISA plan administrative committee's determination.

a. Ordinary meaning analysis

Subrogation is not defined in the Occupational Benefits Plan and its meaning cannot be unambiguously discerned from the Occupational Benefits Plan language. However, as it is ordinarily understood, "subrogation simply means substitution of one person for another; that is, one person is allowed to stand in the shoes of another and assert that person's rights." Black's Law Dictionary 1468 (8th ed. 2004). Put differently, "[i]n a subrogation action, it is well established that there is only one cause of action for the insured's injuries . . . . [and t]he insurer can assert its subrogation claim independently of the insured." *Prudential Prop. and Cas. Co. v. Dow Chevrolet-Olds, Inc.*, 10 S.W.3d 97, 100 (Tex. App. Texarkana 1999). Moreover, under Texas state law, "the subrogees stand in the shoes of the one whose rights they claim." *Interstate Fire Ins. Co. v. First Tape, Inc.*, 817 S.W.2d 142, 145 (Tex. App. Houston 1991). Therefore, if there is only one cause of action for an insured's injuries, and in a subrogated action that cause of action belongs to the insurance company subrogee, it follows that the insurance company subrogee has the right to control the subrogated cause of action.

As applied to the instant case, the Ethridge Estate has a cause of action on behalf of Silvia Ethridge. However, under the clear terms of the Occupational Benefits Plan, by accepting Occupational Benefits Plan death benefits, the Ethridge Estate has subrogated its cause of action to MHHS, which then stands in the shoes of the Ethridge Estate. Because there is only one cause of action, and MHHS received from the Ethridge Estate the right to control that cause of action, as the party in control MHHS is entitled to prosecute and settle the Ethridge Estate's claims without seeking approval from the Ethridge Estate representative.

b. Legally correct interpretation

Moreover, the Administrative Committee gave the meaning of subrogation in the Occupational Benefits Plan a legally correct interpretation under the three-part test employed by this Court to determine the legal correctness of an ERISA administrative committee's determination. *Pickrom v. Belger Cartage Serv., Inc.*, 57 F.3d 468, 471 (5th Cir. 1995). Under the three-part test, this Court considers: (1) whether the administrative committee has given the plan a uniform construction; (2) whether the administrative committee's interpretation is consistent with a fair reading of the plan; and (3) whether different interpretations of the plan will result in unanticipated costs. *Id.*

Regarding the first factor, when there is no evidence in the record as to whether an administrative committee has given the plan a uniform construction, this Court should proceed to the other two factors. *See id.* Because there is no evidence in the record that the Administrative Committee previously had to construe the scope of the

Occupational Benefits Plan's subrogation rights, our analysis necessarily turns to the remaining two factors.

Regarding the second factor, the Administrative Committee's interpretation of the term "subrogation" is consistent with a fair reading of the Occupational Benefits Plan. The Occupational Benefits Plan language limits MHHS' recovery to the extent of "any Benefit payments made under the Plan," but does not limit MHHS' right of subrogation. The Occupational Benefits Plan language, in fact, grants MHHS a broad subrogation right since it states that MHHS "has the right to pursue any action to enforce its subrogation rights against a third party." Therefore, a plain reading of the Occupational Benefits Plan language gives MHHS the right of subrogation to all of the Ethridge Estate's claims, with MHHS' right of recovery in any action against a third party limited to the amount of the death benefit paid to the Ethridge Estate.

Regarding the third factor, a different interpretation of the Occupational Benefits Plan than the one adopted by the Administrative Committee would result in unanticipated costs to MHHS. If, as Shelton argues, MHHS should not be permitted to prosecute or settle any subrogated claims without the consent of an employee's estate as subrogor, MHHS would be at the mercy of the estate. Pursuant to Article 11.3 of the Occupational Benefits Plan, MHHS has priority over an employee's estate with respect to all funds recovered from third parties, up to the amount of benefits MHHS has paid plus the costs of recovery. If MHHS is not permitted to independently prosecute and settle the claims of an employee's estate, MHHS runs the risk that the estate – having already received funds from MHHS – will hold up settlement negotiations in the hopes of obtaining a larger recovery. An estate that has received

funds from MHHS has no incentive to settle its claims for any amount that does not exceed that already paid to it by MHHS, irrespective of how reasonable the settlement offer may be. Adopting an alternate reading of the term "subrogation" would result in unanticipated costs to MHHS, namely the increased costs of recovering from third parties. Accordingly, we conclude that the Administrative Committee has given a legally correct interpretation to the term "subrogation" as it appears in the Occupational Benefits Plan.

Therefore, for the foregoing reasons, we affirm the judgment of the district court upholding the Administrative Committee's interpretation of MHHS' subrogation rights with respect to any claims of the Ethridge Estate, and rejecting Shelton's argument that she should control or share in the control of the prosecution of any actions brought on behalf of the Ethridge Estate.

3. MHHS' claims

MHHS appeals the district court's denial of MHHS' motion for summary judgment and its holding that Ben Ethridge retained his wrongful death cause of action against third parties because he was not a beneficiary of MHHS' Occupational Benefits Plan death benefits. MHHS contends that the Administrative Committee's determination was not an abuse of discretion for the following reasons: (1) because Silvia Ethridge designated Ben Ethridge as a beneficiary of her Life Insurance and Accidental Death & Dismemberment Insurance Plans, Ben Ethridge also should be considered a designated beneficiary of Occupational Benefits Plan death benefits; (2) under Article 8.2 of the Occupational Benefits Plan, MHHS must

pay the Occupational Benefits Plan death benefit as the designated Occupational Benefits Plan beneficiaries request; (3) at the request of Ben Ethridge and Shelton, MHHS made the death benefit check payable to Shelton as the personal representative of the Ethridge Estate; and (4) Ben Ethridge did receive money from Shelton.

We conclude that the Administrative Committee's determination that Ben Ethridge received Occupational Benefits Plan death benefits and was therefore required to comply with the Occupational Benefits Plan's subrogation and assignment provisions is legally incorrect under the first prong of the abuse of discretion standard articulated *supra*.

MHHS has not demonstrated that Ben Ethridge was a recipient of Occupational Benefits Plan death benefits. Although Ben Ethridge did receive life insurance and accidental death and dismemberment insurance proceeds, which are not at issue in the instant case, he did not receive from MHHS any portion of the Occupational Benefits Plan death benefit, nor was he a designated beneficiary of Occupational Benefits Plan benefits. The entire amount of the death benefit was made payable to Dalinda Shelton as the personal representative of the Ethridge Estate; Ben Ethridge did not receive any money directly from MHHS' Occupational Benefits Plan. Moreover, the money Ben Ethridge did receive from Shelton was a gift to Ben Ethridge and was drawn from Shelton's own funds.

Therefore, because the Administrative Committee's determination that Ben Ethridge received Occupational Benefits Plan death benefits is inconsistent with a fair reading of the Occupational Benefits Plan, we conclude

that the Administrative Committee's determination is legally incorrect. *See Gosselink v. Am. Tel. & Tel., Inc.*, 272 F.3d 722, 727 (5th Cir. 2001) (holding that it is an abuse of discretion if an administrative committee interprets a plan in a way that directly contradicts the plain meaning of the plan language). Accordingly, we agree with the decision of the district court denying MHHS' motion for summary judgment as it relates to Ben Ethridge.

B. Carol Pittman

1. Factual and procedural history

Both Carol Pittman, common law wife of the deceased John Pittman, Jr., and John Pittman III and Jennifer Pittman (collectively, the "Pittman children"), the surviving children of the deceased, asserted to MHHS that the $1,000,000 death benefit under the Occupational Benefits Plan be paid to them. Unsure who it should pay, on December 21, 2000, MHHS filed a Petition in Interpleader against Pittman and the Pittman children asking that the probate court administering the Pittman Estate determine who, as between Pittman and the Pittman children, was the appropriate payee. MHHS then deposited the $1,000,000 death benefit into the court registry. The probate court subsequently issued an Agreed Final Judgment ordering that the funds be released to the "personal representative of the Estate of John Linwood Pittman, Jr." The probate court further determined that Pittman was the duly authorized personal representative of the Pittman Estate.

After Pittman accepted the death benefit provided under the Occupational Benefits Plan, she filed a declaratory judgment action in probate court in which Pittman

sought to avoid the subrogation provisions of the Occupational Benefits Plan. MHHS removed Pittman's claim to federal court and Pittman filed a motion to remand. The district court denied Pittman's motion to remand and consolidated the removed action with MHHS' action against the third-party helicopter manufacturer on behalf of, *inter alios,* Carol Pittman and the Pittman Estate.

On July 30, 2003, MHHS filed with the district court a motion for partial summary judgment against Pittman in her capacity as executrix and beneficiary of the Pittman Estate. MHHS contended that summary judgment was appropriate because the Administrative Committee concluded that Pittman had accepted death benefits under the Occupational Benefits Plan and that MHHS had a right of subrogation to the amounts paid by it plus the costs of prosecuting the claim. Pittman also filed with the district court a motion for partial summary judgment against MHHS.

The district court granted MHHS' motion for partial summary judgment and denied Pittman's motion for partial summary judgment. Pittman appeals those adverse judgments against her.

2. Pittman's claims

Pittman concedes that the claims of the Pittman Estate are subject to subrogation because the Pittman Estate received Occupational Benefits Plan death benefits from MHHS. Moreover, as the Pittman Estate's personal representative, Carol Pittman admits she accepted Occupational Benefits Plan death benefits, but did so only on behalf of her deceased husband and not on her own behalf as his wife. As such, Pittman contends that her claims as

an individual are not subject to subrogation because she as an individual did not receive Occupational Benefits Plan death benefits, nor did she as an individual contractually assign her claims to MHHS by executing an Acknowledgment of Receipt of Benefits, Subrogation Rights and Confidentiality Agreement.

The Administrative Committee read the Occupational Benefits Plan language to mean that Pittman, upon receipt of Occupational Benefits Plan death benefits, subrogated all of her rights, in whatever capacity, to MHHS. We conclude that this interpretation amounts to an abuse of discretion because the Administrative Committee, in reaching its conclusion, ignored the plain language of the Occupational Benefits Plan.

Article 11.1 of the Occupational Benefits Plan states that "in the event of any Benefit payments made under the Plan to or on behalf of any Employee, the Plan shall, to the extent of such payments, be subrogated to all the rights of recovery . . . of the Employee." Article 11.1 further states that by participating in the Occupational Benefits Plan, an employee also obligates the legal representative of his estate and that "the Plan shall be fully subrogated to any recovery or right of recovery that the estate may have against any third party." The quoted language plainly means that when an employee or his estate accepts Occupational Benefits Plan benefits, the employee or his estate must surrender to MHHS all of its rights against third parties.

As applied to the instant case, the Occupational Benefits Plan language means only that the Pittman Estate, via Pittman as the estate representative, must surrender its claims to MHHS. The language does not

mean that Pittman must surrender the wrongful death claims she independently possesses as John Pittman, Jr.'s wife merely because she also served as the representative of the Pittman Estate. Because Pittman took Occupational Benefits Plan death benefits as the Pittman Estate representative – and not in her individual capacity – she cannot be made to subrogate to MHHS the wrongful death claims she independently possesses in her individual capacity as the decedent's wife. In other words, MHHS acquired no subrogation rights nor control of any of Pittman's individual claims. Accordingly, we reverse the judgment of the district court insofar as it granted MHHS' motion for summary judgment with respect to Pittman in her individual capacity, and remand the case to the district court for proceedings not inconsistent with this opinion.

IV. CONCLUSION

For the foregoing reasons, the judgment of the district court is AFFIRMED in part and REVERSED and REMANDED in part.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CHARLES ATTEBERRY, SR., ET AL.	§	**CIVIL ACTION NO. H-02-3689**
Plaintiffs,	§	
versus	§	
EUROCOPTER DEUTSCHLAND GMBH, ET AL.	§	
Defendants.	§	

ORDER

(Filed Dec. 1, 2003)

Pending before this Court is the Plaintiff's Motion for Partial Summary Judgement **(Instrument No. 125)**. Based on the parties' submissions and applicable law, the Court finds that Plaintiffs Motion **(Instrument No. 125)** is **DENIED**.

I.

On July 17, 1999 a Eurocopter BK-117 helicopter, owned and operated by Memorial Hermann Healthcare and Memorial Hermann Hospital Systems ("MHHS") as a Life Flight emergency aircraft, crashed near Fresno, Texas. All MHHS employees aboard the helicopter were killed. At the time of their deaths, the employees were covered by MHHS' ERISA Occupational Benefits Plan (the "Plan"), which provided death benefits of $1,000,000.00 to each employee's beneficiaries. John Linwood Pittman, Jr. was the pilot of the helicopter and one of the employees who died.

On August 1, 2003 Plaintiff Carol Ann Pittman, a.k.a Carol Ann Peterson, Independent Executrix of the Estate of John Linwood Pittman, Jr., Deceased and Individually as Beneficiary of John Linwood Pittman, Jr. filed a motion for summary judgment requesting that the Court find that MHHS' subrogation claims are barred by *res judicata* or in the alternative that MHHS' claims are not equitable claims authorized under ERISA. (Instrument No. 125). The Court recognizes that this motion for summary judgment also serves as a response to MHHS' earlier motion for partial summary judgment. (Instrument No. 121).

Plaintiff argues that the re-litigation of MHHS' subrogation claim is barred under the doctrine of *res judicata* as it was already decided in May 2000, when the Probate Court of Galveston County entered an "Agreed Final Judgment" in MHHS' Interpleader Action. (Instrument No. 126, at 2). Plaintiff contends that MHHS filed a "Petition in Interpleader" in the Probate Court in Galveston County, affirmatively asking for MHHS to be "discharged from any further obligation with regard to decedents death [and] that Memorial Hermann has a right of subrogation. . . . " (Id., Exh. 2 at 4). The Probate Court signed an Agreed Final Judgment that granted MHHS' request to be discharged from any further obligation and "ORDERED, ADJUDGED AND DECREED that any and all relief not specifically granted herein is denied." (Id., Exh. A, at 2). Therefore, Plaintiff asserts that the Probate Court was "implicitly addressing Memorial's affirmative subrogation claims . . . " (Id., at 9).

According to Plaintiff, whether one looks at MHHS' subrogation claim as an action barred by issue preclusion (collateral estoppel), which prevents re-litigation of issues

that have already been resolved in a prior suit, or claim preclusion (*res judicata*), which bars re-litigation of claims or causes of action that have already been adjudicated or should have been adjudicated, the elements for each are satisfied. (Instrument No. 125, at 7-8).

Alternatively, Plaintiff claims that the Supreme Court has recently held that an ERISA plan administrator may not seek to enforce a contractual obligation for the payment of money in federal court because ERISA only permits suits that seek to obtain "appropriate equitable relief." Plaintiff refers to *Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002) and *Bahaus USA, Inc. v. Copeland,* 292 F.3d 439 (5th Cir. 2002) to support her position. (Id.).

On August 20, 2003, Memorial Hermann Healthcare and Memorial Hermann Hospital Systems filed its Response to Carol Ann Peterson Pittman's Motion for Summary Judgment. (Instrument No. 132). MHHS argues that the Agreed Final Judgment signed by the Galveston Probate Court on May 5, 2000 was not a ruling by the court regarding the assignment of claims or subrogation rights pursuant to the terms and provisions of the Plan. (Id., at 5). MHHS notes that it is Carol Ann Pittman who filed an Original Petition for Declaratory Judgment in the Galveston Probate Court on August 1, 2000, seeking to have the rights and obligations of the parties with respect to MHHS' subrogation rights and right to require assignment of all claims against third party action resulting from the helicopter crash, determined by declaratory judgment. (Id., at Exh. C). It is this same declaratory judgment action that was removed to federal court by MHHS on September 11, 2000 by MHHS and ultimately

consolidated with this present case on August 7, 2000 by Judge Samuel B. Kent. (Id., at Exh. E).

MHHS alleges that ERISA regulates employee benefit plans such as the occupational benefits program at issue in this case. (See 29 U.S.C. Section 1001; *NGS America, Inc. v. Barnes,* 998 F.2d 296, 298 (5th Cir. 1993). ERISA includes a preemption provision that states that it shall "supercede any and all State laws." 29 U.S.C. section 1144(a). MHHS argues that caselaw supports their position, that under ERISA, when an occupation benefit plan vests its administrator with discretionary and final authority to determine eligibility and interpret the plan, the Court reviews the administrator's, decisions for abuse of discretion. (Instrument No. 132, at 6).

According to MHHS, the Plan Administrative Committee met to interpret and construe the Plan. The Committee determined that John Pittman, Jr. was an eligible employee under the Plan and that his estate was eligible for benefits under the Plan. MHHS also claims that the Committee concluded that the estate and beneficiaries were subject to the Plan's terms and conditions. MHHS asserts that it is apparent that the Administrator construed the Plan uniformly and in a manner consistent with a fair reading of the Plan's plain language, thus the effect of a beneficiary's acceptance of benefits is clearly established by the Plan as set out in Article XI, section 11.2 quoted above. (Instrument No. 132, at 7).

In Article XI of Section 11.2 of the Plan provides:

> *Employee's Agreement to Subrogation.* Employee on behalf of himself and each beneficiary of payment made on Employee's behalf, by accepting Benefits under the plan consents and agrees (i)

> that the Plan shall be promptly reimbursed for any payments made to or on the Employee's behalf under the Plan out of any monies recovered as the result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement. . . . Furthermore, Employee and said beneficiaries promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, reimbursement agreements and other instruments as the Plan Administrator may require to facilitate enforcement of the Plan's subrogation rights. . . .

(Instrument No. 132, Exh. A, Art. XI, Sect. 11.2)

MHHS' Benefit Plan contains a subrogation provision at Article XI, § 11.2 which MHHS' Administrative Committee claims has only one reasonable interpretation which is "that anyone who receives benefits paid under the Plan is required, upon the request of the administrator to assign to the Plan any claims which he or she may have." (Instrument No. 132, at 8).

On May 15, 2000, Judge Gladys B. Burwell signed an Agreed Final Judgment, ordering that the funds previously placed in the registry of the court be paid to the personal representative of the Estate of John Linwood Pittman, Jr. The court further found that Carol Ann Pittman is the duly authorized personal representative of the Estate of John Linwood Pittman, Jr. (Instrument No. 132, at Exh. B).

According to MHHS, the Agreed Final Judgment was entered after, Carol Pittman and her attorney had been provided the Plan and had ample time and opportunity to study its provisions before she accepted the benefits.

MHHS asserts that Carol Ann Pittman "indisputable,[sic] knowingly, and voluntarily accepted benefits" and because she "accepted benefits under the Plan, MHHS is entitled, as the Administrative Committee found, to require her, individually, to assign any and all rights of recovery she may have to MHHS." (Instrument No. 132, at 8). Additionally, MHHS argues that the cases Carol Ann Pittman relies on are distinguishable. (Id., at 9).

II.

Summary judgment is appropriate if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56. A fact is "material" if its resolution in favor of one party might affect the outcome of the suit under governing law. *See Anderson v. Liberty Lobby, Inc.*, 47 U.S. 242, 247 (1986); *see also United States v. Arron*, 954 F. 2d 249, 251 (5th Cir. 1992). An issue is "genuine" if the evidence is sufficient for a reasonable jury to return a verdict for the nonmoving party. *See Anderson*, 47 U.S. at 247. If the evidence rebutting the motion for summary is only colorable or not significantly probative, summary judgment should be granted. *Id.* at 247-48; *see also Thomas v. Barton Lodge, Ltd.*, 174 F. 3d 636, 644 (5th Cir. 1999). The summary judgment procedure, therefore, enables a party "who believes there is no genuine issue as to a specific fact essential to the other side's case to demand at least one sworn averment of that [specific] fact before the lengthy process continues." *See Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 888-89 (1990).

Under Rule 56(c), the moving party bears the initial burden of informing the district court of the basis for its

belief that there is an absence of a genuine issue for trial, and for identifying those portions of the record that demonstrate such absence. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986); *see also Burge v. Parish of St. Tammany*, 187 F. 3d 452, 464 (5th Cir. 1999).

Where the moving party has met its Rule 56 (c) burden, the nonmovant "must do more than simply show that there is some metaphysical doubt as to the material facts . . . [T]he nonmoving party must come forward with 'specific facts showing that there is a genuine issue for trial.'" *See Matsushita*, 475 U.S. at 586 (quoting Fed. R. Civ. P. 56 (e)) (emphasis in original); *see also Celotex Corp v. Catrett*, 477 U.S. 317, 321-22 (1986); *Engstrom v. First Nat'l Bank*, 47 F. 3d 1459, 1462 (5th Cir. 1995). To sustain the burden, the nonmoving party must produce evidence admissible at trial. *See Anderson*, 47 U.S. at 256-57; *see also Thomas v. Price*, 975 F. 2d 231, 235 (5th Cir. 1992) ("To avoid a summary judgment, the nonmoving party must adduce admissible evidence which creates a fact issue.").

The Court reviews the facts in the light most favorable to the nonmovant and draws all reasonable inferences in favor of the nonmovant. *See Brown v. Bunge Corp.*, 207 F. 3d 776, 781 (5th Cir. 2000). "The mere existence of a scintilla of evidence in support of plaintiff's position will be insufficient; there must be evidence on which the jury could reasonably find for the plaintiff." *Anderson*, 47 U.S. at 252.

III.

A.

Plaintiff claims that MHHS' subrogation claim is an action barred by issue preclusion (collateral estoppel), which prevents re-litigation of issues that have already been resolved in a prior suit, or claim preclusion (*res judicatar*), which bars re-litigation of claims or causes of action that have already been adjudicated or should have been adjudicated. However, the subrogation claims Carol Ann Pittman is requesting summary judgment on, stem from the declaratory action that she filed on August 1, 2000, in Galveston County Probate Court and was then removed to federal court and consolidated into this case, and is an entirely new lawsuit from MHHS' Interpleader Action which was decided in May 2000. This demonstrates to the Court that Carol Ann Pittman did not believe that the Agreed Final Judgment signed by the Galveston County Probate Court on May 15, 2000 and ended MHHS' Interpleader Action resolved the subrogation issues, since she proceeded to file a declaratory action the following August. Therefore, the evidence in the record does not support Plaintiff Carol Ann Pittman's assertion that *res judicata* or collateral estoppel applies.

B.

Plaintiff Carol Ann Pittman also claims that the Supreme Court holds that an ERISA plan administrator may not seek to enforce a contractual obligation for the payment of money in federal court because ERISA only permits suits that seek to obtain "appropriate equitable relief" Ms. Pittman argues that the Supreme Court outlines this proposition in *Great-West Life & Annuity Ins.*

Co. v. Knudson, 534 U.S. 204 (2002) and that the Fifth Circuit supports it in *Bahaus USA, Inc. v. Copeland*, 292 F.3d 439 (5th Cir. 2002).

In *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002) Respondent Janette Knudson was injured in a car accident in June 1992 in California. The health plan of Petitioner Earth Systems, Inc., the employer of Ms. Knudson's former husband, covered $411,157.11 of her medical expenses, most of which was paid by petitioner Great-West Life & Annuity Insurance Co. The Plan's reimbursement provision gave it the right to recover from a beneficiary any payment for benefits paid by the Plan that the beneficiary is entitled to recover from a third party. A separate agreement assigned Great-West the Plan's rights to any reimbursement provision claim. After the Knudsons filed a state-court tort action to recover from the manufacturer of their car, they negotiated a settlement which allocated the bulk of the recovery to attorney's fees and to a trust for Janette's medical care, and earmarked $13,828.70 (the portion of the settlement attributable to past medical expenses) to satisfy Great-West's reimbursement claim. After approving the settlement, the state court ordered the defendants to pay the trust amount directly and the remainder to respondents' attorney, who, in turn, would tender checks to Great-West and other creditors. Instead of cashing its check, Great-West filed a federal action under § 502(a)(3) of ERISA codified at 29 U.S.C. § 1132(a)(3) to enforce the Plan's reimbursement provision by requiring the Knudsons to pay the Plan $411,157.1.1 of any proceeds recovered from third parties.

In relevant part, 29 U.S.C.§ 1132(a)(3) states:

> (a) Persons empowered to bring a civil action. A civil action may be brought –
>
> . . .
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

The Knudsons filed a motion for summary judgment which the district court granted, holding that the terms of the Plan limited its right of reimbursement to the $13,828.70 determined by the state court. The Court of Appeals affirmed on different grounds, holding that judicially decreed reimbursement for payments made to a beneficiary of an insurance plan by a third party is not "equitable relief" authorized by § 502(a)(3). The Supreme Court held that because petitioners Great-West Life & Annuity Insurance Co. and Earth Systems, Inc. were seeking legal relief – the imposition of personal liability on respondents for a contractual obligation to pay money – § 502(a)(3) did not authorize the action. *See id.* at 221.

The Fifth Circuit concluded that the facts in *Bahaus USA, Inc. v. Copeland* were indistinguishable in principle from *Great-West.* 292 F .3d 439 (5th Cir. 2002).

> Both cases involve ERISA-governed employee benefit plans that include reimbursement provisions allowing the plans to recover from any settlement proceeds any amount the plans advanced for medical expenses resulting from third party wrong-doing. Third-party tortfeasors injured

> the plan beneficiaries in both cases, and the plans advanced funds to the beneficiaries for medical expenses. In both cases, the plan beneficiaries made tort settlements with third-party tortfeasors following suit in state court. In both, the plan administrator or assignee filed suit in the federal district court seeking declaratory relief that it was entitled to repayment of the benefits it had conferred. In the instant case, the settlement proceeds are in the registry of the Mississippi Chancery Court. In *Great-West*, the proceeds of the settlement were placed in a private Special Needs Trust outside the possession and control of the plan beneficiary. Nevertheless, the defendants in this case, like the Knudsons in *Great-West*, are not in possession of the disputed funds, a fact that Justice Scalia found extremely important in *Great-West*.
>
> The Court in *Great-West* characterized the suit in that case as "[a] claim for money due and owing under a contract" and that such a suit is "quintessentially an action at law." Because the facts in today's case are, in principle, indistinguishable from those in *Great-West*, we are bound by that decision and hold that § 502(a)(3) does not authorize Bauhaus' suit.

Bahaus USA, Inc., 292 F.3d 439, 445.

However, the facts of this case are wholly different. In this case, MHHS is seeking equitable subrogation. Equitable subrogation, "is not dependent upon contract but arises by operation of law or by implication in equity to prevent injustice." *Id.*; *see also* 11 John Alan Appleman & Jean Appleman, Insurance Law § 6501 (1981) ("Legal subrogation has been defined as the right to be subrogated to the creditor's position, arising from the mere fact of payment

by a surety."). Under Texas law, equitable subrogation has been defined as "'a legal fiction by force of which an obligation, extinguished by payment made by a third person, is treated as still subsisting for his benefit'" or "'the procedure by which the equitable rights of one person are worked out through the legal rights of another.'" *Texas Co. v. Miller,* 165 F.2d 111, 115 (5th Cir. 1947) (citations omitted); *see also* 73 AM. JUR. 2D *Subrogation* §§ 2, 3 (1964).

MHHS' Benefit Plan contains a subrogation provision at Article XI, § 11.2 which MHHS's Administrative Committee claims has only one reasonable interpretation which is "that anyone who receives benefits paid under the Plan is required, upon the request of the administrator to assign to the Plan any claims which he or she may have." (Instrument No. 133, at 11). ERISA also allows for a civil action "to obtain other appropriate equitable relief . . . or to enforce any provisions of this title or the terms of the plan." *See* 29 U.S.C.§ 1132(a)(3).

MHHS has provided the Court with evidence that it paid death benefit monies pursuant to the Plan to Carol Ann Pittman and has a subrogation interest in her wrongful death claim. The documentation provided to the Court by MHHS including the Agreed Final Judgement which clearly states that the parties MHHS, Carol Ann Pittman and the Pittman Children agreed that the funds previously placed in the Galveston County Probate Court's registry by MHHS "shall be paid to the personal representative of the Estate of John Linwood Pittman. Jr. Further, the Court finds that Carol Ann Pittman, a k a Carol Ann Peterson is the duly authorized personal representative of the Estate of John Linwood Pittman, Jr." (Instrument No. 133, at Exh. D). Additionally, the December 1, 2000 letter

authored by Carrol E. Aulbaugh of the Administrative Committee, support the Pittman Children's contention that it was Carol Ann Pittman who has accepted benefits of the Occupational Benefits Plan. (Instrument No. 133, Exh. C). In fact, this Court granted, in its Order dated November 21, 2003, MHHS' Motion for Partial Summary Judgment as to Carol Ann Pittman, granting MHHS subrogation rights and the exclusive and sole authority to direct prosecution of Carol Ann Pittman's wrongful death claims.

Because MHHS, in this case, is seeking an equitable relief the caselaw cited by Plaintiff does not apply. MHHS is not asking Carol Ann Pittman to pay any monies, only for the equitable relief of subrogation provided for by ERISA and MHHS' Plan.

IV.

Based on the foregoing, the Court **DENIES** Plaintiff's Motion for Summary Judgment **(Instrument No. 125)**.

The Clerk shall enter this Order and provide a copy to all parties.

SIGNED on this the 28th day of November, 2003, at Houston, Texas.

/s/ Vanessa D. Gilmore
VANESSA D. GILMORE
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CHARLES ATTEBERRY, SR., ET AL.	§	
	§	
Plaintiffs,	§	
	§	**CIVIL ACTION NO.**
versus	§	**H-02-3689**
	§	
EUROCOPTER DEUTSCHLAND GMBH, ET AL.	§	
	§	
Defendants.	§	

ORDER

(Filed Feb. 26, 2004)

Pending before this Court is Memorial Hermann's Motion for Partial Summary Judgement **(Instrument No. 178).**

I.

On July 17, 1999 a Eurocopter BK-117 helicopter, owned and operated by Memorial Hermann Healthcare and Memorial Hermann Hospital Systems ("MHHS") as a Life Flight emergency aircraft, crashed near Fresno, Texas. All MHHS employees aboard the helicopter were killed. At the time of their deaths, the employees were covered by MHHS' ERISA Occupational Benefits Plan (the "Plan"), which provided death benefits of $1,000,000.00 to each employee's beneficiaries. Charles Atteberry, Jr. was one of the employees who died.

On August 7, 2000, Charles Atteberry, Sr. and Judy Atteberry, Individually and as Co-Administrators of the Estate of Charles Atteberry Jr., and MHHS on behalf and

for the benefit of the Estates, Heirs, Devisees, Legatees, Spouses, Children and/or Parents of Charles Atteberry, Jr., Lynn Ethridge and John Pittman[1] filed an Original Complaint in this Court claiming that Eurocopter is liable for all claims including but not limited to negligence and/or strict liability, related to the design, testing, manufacture, quality control, and marketing of the BK-117-B2, the helicopter at issue. (Instrument No. 1).

On December 1, 2003, MHHS filed a Motion for Partial Summary Judgment. (Instrument No. 178). MHHS seeks summary judgment on the issue of its right and authority to settle this lawsuit. MHHS has reached a settlement agreement with Defendants Eurocopter Deutschland, GMBH, Eurocopter SA, Eurocopter Holding SA and Honeywell International Inc. (collectively "Defendants"). However, MHHS claims that the settlement has been frustrated by a dispute that has arisen between MHHS and one of the Plaintiff families, Charles Atteberry, Sr. and Judy Atteberry ("Atteberrys"), concerning MHHS' subrogation rights and its authority to settle this lawsuit. MHHS argues that their ERISA Occupational Benefits Plan contains unambiguous provisions requiring that anyone receiving benefits on behalf of an employee under the Plan assign to MHHS all rights of recovery that the employee's estate may have against third parties who are potentially liable for an employee's death. Specifically,

[1] Charles Atteberry, Sr. and Judy Atteberry dispute MHHS' assertion that it filed suit on their behalf. Charles Atteberry, Sr. and Judy Atteberry contend that "the complaint clearly reflects that [the] suit was filed by them on their own behalf, with Memorial Hermann as a plaintiff, seeking to recover damages because of their subrogation rights." (Instrument No. 187, at 5).

MHHS cites Article 11.1 of the ERISA Plan which provides in relevant part:

> In the event of any Benefit payments made under the Plan to or on behalf of any Employee, the Plan shall, to the extent of such payments, be subrogated to all the rights of recovery and other rights of the Employee arising out of any claim or cause of action which may accrue because of the alleged accidental, negligent, intentional, or tortious conduct, act, or omission of another person or entity. . . . Employee, by participation in the Plan agrees that his estate, and the legal representative of his estate, shall likewise be obligated and that the Plan shall be fully subrogated to any recovery or right of recovery that the estate may have against any third party on account of, arising out of, the Employees's bodily Injury, Disease or Commutative Trauma, *including without limitation, any wrongful death claim or action*. . . . The Plan Administrator, on behalf of the Plan, also has the right to pursue any action to enforce its subrogation rights against a third party. . . .

Article 11.2 provides:

> *Employee's Agreement to Subrogation.* Employee on behalf of himself and each beneficiary of payment made on Employee's behalf, by accepting Benefits under the plan consents and agrees (i) that the Plan shall be promptly reimbursed for any payments made to or on the Employee's behalf under the Plan out of any monies recovered as the result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement . . . .

Furthermore, Employee and said beneficiaries promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, reimbursement agreements and other instruments as the Plan Administrator may require to facilitate enforcement of the Plan's subrogation rights. . . .

(Instrument No. 178, at Exh. A)

MHHS argues that the Plan's Administrative Committee confirms that the construction given by the Committee to the above provisions is that the effect of a beneficiary's acceptance of Plan benefits is that the Plan acquires subrogation rights and has the right to control the settlement of all claims against third parties who are potentially liable for the death of the employee. (Instrument No. 187, at 4). MHHS also argues, that "this Court recently held that the acceptance of Plan monies by a beneficiary gives MHHS the sole authority to direct prosecution of that beneficiary's subrogation claims." (Id.).

MHHS states that the Atteberrys' have received and accepted benefits pursuant to MHHS' ERISA Plan. As well as MHHS claims that the Atteberrys executed an agreement with the Plan Administrator, specifically acknowledging their receipt of benefits under the ERISA plan, as well as MHHS' subrogation rights. The Acknowledgment of Receipt of Benefits, Subrogation Rights and Confidentiality Agreement ("Agreement") states in relevant part:

> WHEREAS, Claimants and Memorial Hermann desire to resolve fully and finally all claims of entitlement to occupational employee injury benefits arising out of or related to the Incident and/or any benefits to be paid as a result thereof;

> *Subrogation.* Claimants further acknowledge and agree to protect the subrogation rights of Memorial Hermann to any monies that might be recovered from any third party either by judgment, order, award, settlement, compromise, arbitration, or other arrangement a reflected in but not limited The Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare System. Claimants agree that the right of subrogation by Memorial Hermann is primary to any recovery to the extent of any payments made by Memorial Hermann. . . . Memorial Hermann and Claimants agree that the Memorial Hermann shall be entitled only to the first $1 million dollars in gross recovery from any third party.
>
> Claimants further agree to cooperate fully with Memorial Hermann and its attorneys in the prosecution of its subrogation claims and will do nothing to impede, jeopardize or prejudice those rights and/or claims. Memorial Hermann agree that it will not settle the subrogation litigation without consulting with Claimants.

(Instrument No. 178, Exh. C, at 2-3). MHHS argues that the Plan and the Acknowledgment give MHHS the subrogation rights as well as the authority to prosecute and to settle the Atteberrys' subrogation claims. MHHS contends that because the Atteberrys actually received benefits under the Plan, they are subject to the Plan's subrogation provisions, which require them to execute any assignment necessary to facilitate the enforcement of the Plan's subrogation rights.

However, according to MHHS, the Atteberrys have sought to avoid these documents in order to frustrate the

settlement agreement reached between MHHS and Defendants. (Instrument No. 178, at 6). The agreement between MHHS and the Defendants is contingent upon either the presentation of a release agreement executed by the Atteberrys – and the Atteberrys have refused to sign such a release – or on a Court Order finding that Memorial Hermann has the right to settle the Atteberrys' claims. Therefore, MHHS requests that the Court to declare that, because the Atteberrys accepted Plan benefits and acknowledged MHHS' right to prosecute their subrogation claims, MHHS owns the Atteberrys' subrogation claims and may settle the claims on the Atteberrys' behalf without their signature. (Id.).

On December 22, 2003, Charles and Judy Atteberry filed a Response in Opposition to Memorial Hermann's Motion for Partial Summary Judgment. (Instrument No. 187). The Atteberrys assert that MHHS is not entitled to partial summary judgment because MHHS has no pleading supporting a judgment, its ERISA Plan limits its rights only to the extent of payment, and the subsequent agreement between MHHS and the Atteberrys limit MHHS' right to subrogation to only receive payment of monies received, not to force the Atteberrys to settle or assign to MHHS all of their rights, claims and causes of action against the Defendants. (Id., at 1).

The Atteberrys contend that Rule 56(a) of the Federal Rules of Civil Procedure, "requires that a movant have pleadings supporting the requested judgment." (Id., at 8). The Atteberrys argue that notwithstanding MHHS' motion for partial summary judgment, MHHS had not filed any pleadings asserting any claims against the Atteberrys or that support its right to ask the Court to enter a declaratory judgment in its favor. (Id.).

The Atteberrys also claim that the January 27, 2000 Agreement between MHHS and the Atteberrys supercedes the ERISA Plan and "does not grant MHHS the power or right to force the Atteberrys to assign all of their rights, claims and causes of action to Memorial Hermann or grant Memorial Hermann the power to settle the Atteberrys' claims against the defendants." (Id., at 8). The Agreement contains a merger clause that states – "This agreement sets forth the entire agreement between the parties hereto, and fully supercedes any and all prior agreements, representations, promises or understandings, written or oral, between the parties hereto pertaining to the subject matter hereof. This Agreement cannot be changed, modified, or altered except in writing, signed by both Claimants and Memorial Hermann," (Id., at 9). Accordingly, the Atteberrys argue that the Court should disregard the ERISA Plan and only look to the Agreement to determine whether MHHS has the legal right to force an assignment or settle the Atteberrys' claims.

The Atteberrys contend that the Agreement does not require an assignment and in fact limits MHHS' rights to subrogation to $1,000,000. (Instrument No. 187, at 10). According to the Atteberrys, the "[a]greement clearly contemplates that the Atteberrys had the right to prosecute their claims against the defendants." (Id.). Further, the Atteberrys recognize that the Agreement contemplates that MHHS has the right to settle its subrogation claim, but is required to consult with the Atteberrys before doing so. The Atteberrys do not object to MHHS settling its subrogation claims so long as the settlement does not preclude the Atteberrys from continuing their claims against the defendants, "especially in light of the fact that

the current offer does not contemplate compensating the Atteberrys." (Id., at 12).

The Atteberrys also argue that even if the Court finds that the Agreement does not supercede MHHS' ERISA Plan, the Plan does not provide MHHS with the power or right to require the Atteberrys to assign all of their rights, claims and causes of action to MHHS or to allow MHHS to settle both its subrogation claims but also the Atteberrys' claims. The Atteberrys maintain that the Plan "by its own terms limits Memorial Hermann's right only to the amount paid." (Id., at 13). The Plan provides the following:

> 11.1 *Plan's Right of Subrogation.* In the event of any Benefit payments made under the Plan to or on behalf of any Employee, the Plan shall, to the extent of such payments, be subrogated to all the rights of recovery and other rights of the Employee arising out of any claim or cause of action which may accrue because of the alleged accidental, negligent, intentional, or tortious conduct, act, or omission of another person or entity. . . . Employee, by participation in the Plan agrees that his estate, and the legal representative of his estate, shall likewise be obligated and that the Plan shall be fully subrogated to any recovery or right of recovery that the estate may have against any third party on account of, arising out of, the Employees's Bodily Injury, Disease or Commutative Trauma, including without limitation, any wrongful death claim or action. . . . The Plan Administrator, on behalf of the Plan, also has the right to pursue any action to enforce its subrogation rights against a third party. . . .
>
> 11.3 *Limitations To Plan's Subrogation Rights.* The Plan's subrogation rights (a) shall extend only to the recovery by the Plan of (i) the Benefits that

> it has paid or will pay to or on behalf of the Employee and (ii) the cost of prosecuting the claims including attorney's fees and court and collection costs and (b) shall fully apply even if Participant or beneficiary thereof has only received a partial recovery from a third party.

(Instrument No. 178, Exh. A). The Atteberrys argue that the Court should deny MHHS' motion for partial summary judgment, because MHHS is only entitled to seek recovery of subrogation up to amounts paid and that no where do the documents grant MHHS the right or power to settle all of the Atteberrys' claims or causes of action. (Instrument No. 187, at 14).

II.

Summary judgment is appropriate if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56, A fact is "material" if its resolution in favor of one party might affect the outcome of the suit under governing law. *See Anderson v. Liberty Lobby, Inc.*, 47 U.S. 242, 247 (1986); *see also United States v. Arron*, 954 F. 2d 249, 251 (5th Cir. 1992). An issue is "genuine" if the evidence is sufficient for a reasonable jury to return a verdict for the nonmoving party. *See Anderson*, 47 U.S. at 247. If the evidence rebutting the motion for summary is only colorable or not significantly probative, summary judgment should be granted. *Id.* at 247-48; *see also Thomas v. Barton Lodge, Ltd.*, 174 F. 3d 636, 644 (5th Cir. 1999). The summary judgment procedure, therefore, enables a party "who believes there is no genuine issue as to a specific fact essential to the other side's case to demand at least one sworn averment of that [specific] fact before the lengthy

process continues." *See Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 888-89 (1990).

Under Rule 56 (c), the moving party bears the initial burden of informing the district court of the basis for its belief that there is an absence of a genuine issue for trial, and for identifying those portions of the record that demonstrate such absence. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986); *see also Burge v. Parish of St. Tammany*, 187 F. 3d 452, 464 (5th Cir. 1999).

Where the moving party has met its Rule 56 (c) burden, the nonmovant "must do more than simply show that there is some metaphysical doubt as to the material facts . . . [T]he nonmoving party must come forward with 'specific facts showing that there is a genuine issue for trial.'" *See Matsushita*, 475 U.S. at 586 (quoting Fed. R. Civ. P. 56 (e)) (emphasis in original); *see also Celotex Corp v. Catrett*, 477 U.S. 317, 321-22 (1986); *Engstrom v. First Nat'l Bank*, 47 F. 3d 1459, 1462 (5th Cir. 1995). To sustain the burden, the nonmoving party must produce evidence admissible at trial. *See Anderson*, 47 U.S. at 256-57; *see also Thomas v. Price*, 975 F. 2d 231, 235 (5th Cir. 1992)("To avoid a summary judgment, the nonmoving party must adduce admissible evidence which creates a fact issue.").

The Court reviews the facts in the light most favorable to the nonmovant and draws all reasonable inferences in favor of the nonmovant. *See Brown v. Bunge Corp.*, 207 F. 3d 776, 781 (5th Cir. 2000). "The mere existence of a scintilla of evidence in support of plaintiff's position will be insufficient; there must be evidence on which the jury could reasonably find for the plaintiff" *See Anderson*, 47 U.S. at 252.

III.

Subrogation was first recognized as a right in equity to prevent the unjust enrichment of a party who was owed a claim that had been satisfied by another party. Later the equitable right was preserved and sometimes extended by incorporating it into the contract between the claim-debtor and the party who, although not ultimately liable for the claim, satisfied it. Whether subrogation is equitable or conventional or both, the subrogee does not obtain redress in its own right but only as successor to the rights of the subrogor. Accordingly, a subrogee can obtain no greater rights than its subrogor had. *See In re Complaint of Admiral Towing & Barge Co.*, 767 F.2d 243, 250 (5th Cir. 1985)

The January 27, 2000 Agreement between MHHS and the Atteberrys was clearly meant to supercede the ERISA Plan. The language is clear that the parties intended for the Agreement to "set[] forth the entire agreement between the parties hereto, and fully supercede[] any and all prior agreements, representations, promises or understandings, written or oral, between the parties hereto pertaining to the subject matter hereof" (Instrument No. 178, Exh. C, at 5). Therefore, the Court finds that the Agreement supercedes MHHS' ERISA Plan and will focus on its language in the analysis.

MHHS interprets the Agreement to give MHHS the subrogation rights as well as the authority to prosecute and to settle the Atteberrys' claims, and requires the Atteberrys to execute any assignment necessary to facilitate the enforcement of the Plan's subrogation rights. The Atteberrys contend that the Agreement does not require

an assignment and in fact limits MHHS' rights to subrogation to $1,000,000.

This issue is but a disagreement over contract interpretation. The primary objective in contract interpretation is to give effect to the intent of the contracting parties as revealed by the language they chose to use. In a contract dispute a motion for summary judgment may be granted only where the agreement's language is unambiguous and conveys a definite meaning. If the language is susceptible to different reasonable interpretations, and where there is relevant extrinsic evidence of the parties' actual intent, then the contract's meaning becomes an issue of fact precluding summary judgment. *Sayers v. Rochester Tel. Corp. Supplemental Management Pension Plan*, 7 F.3d 1091, 1094 (2d Cir. 1993) (internal citations and quotations omitted).

Ascertaining whether or not a writing is ambiguous is a question of law for the trial court. *See id.* "Contract language is ambiguous if it is capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business. No ambiguity exists when contract language has a definite and precise meaning, unattended by danger of misconception in the purport of the contract itself, and concerning which there is no reasonable basis for a difference of opinion." *Id.* (internal citations, quotations, and alterations omitted). In interpreting the terms of a contract, the Court must consider the entirety of the agreement, including any references therein, and "safeguard against adopting an interpretation

that would render any individual provision superfluous." *Id.*

The Atteberrys' argument rests on the fact that the Agreement states that MHHS "shall be entitled only to the first $1,000,000 in gross recovery from any third party." (Instrument No. 178, Exh. C at 3). According to the Atteberrys, the Agreement clearly contemplates that they have the right to prosecute their claims against the defendants, because the Agreement provides that the Atteberrys were responsible for attorney's fees for all recoveries over and above the first $1,000,000. The Agreement also provides that MHHS "will not settle the subrogation litigation without consulting with Claimants," which the Atteberrys read as confirmation that MHHS does not have the right to force them to assign all of their rights, claims and causes of action against the defendants.

The language in the subrogation section of the Agreement first acknowledges "that the right of subrogation by Memorial Hermann is primary to any recovery. . . . " It is a common in ERISA plans to have subrogation clauses. However,

> [w]hile they vary widely in precise operation and effect, they share the goal of limiting the total expenditure of plan assets. Subrogation accomplishes this by permitting the plan to "stand in the shoes" of the beneficiary with respect to tort or other recoveries to which the beneficiary is entitled on account of the injuries for which the plan has paid benefits. This prevents the beneficiary from recovering twice-once from the plan, and once from the tortfeasor. . . . Subrogation is frequently confused with reimbursement, owing perhaps to the frequency with which both provisions are included in ERISA plans, The key distinction

> is that subrogation in effect assigns (or requires assignment of) the tort claim to the subrogee (the plan). Reimbursement simply requires the successful owner of the tort claim (the beneficiary) to repay the plan's advances.

Waller v. Hormel Foods, 950 F. Supp. 941, 944 (D. Minn. 1996).

The Agreement language limits MHHS' recovery, to "the extent of any payments made by Memorial Hermann," not their right of subrogation. The intent of the language is clear, MHHS has the right to subrogate all of the Atteberrys' claims, thus they "stand in the shoes" of the beneficiary, but they are limited to receiving only the amount they actually paid to the Atteberrys, $1,000,000. Therefore, if MHHS received more than the $1,000,000 paid to the Atteberrys, the remainder would go to the Atteberrys. The Atteberrys' interpretation would render the terms of the Agreement superfluous and meaningless. MHHS would not have the ability to settle, thus their right of subrogation would not be "primary to any recovery" as set out in the Agreement.

The Agreement also refers to the Plan to provide examples of the ways in which MHHS would be able to recover monies from a third party. The Agreement states that "any monies that might be recovered from any third party either by judgment, order, award, settlement, compromise, arbitration, or other arrangement as reflected in but not limited to The Occupational Benefits for the Employees of Memorial Hermann Healthcare System." The Plan states that it "also has the right to pursue any action to enforce its subrogation rights against a third party." (Instrument No. 178, Exh. A, at 11.1). Now that MHHS has the right to "stand in the shoes" of the Deceased's beneficiaries, due to the payment of

benefits and the terms of the Agreement, "any action" would include the ability to settle the claims of the Deceased. In addition, "any action" would also include seeking a declaratory judgment as to MHHS' subrogation rights.

Therefore, after reading the Agreement in its entirety, the Court does not find the provision at issue to be reasonably susceptible to differing interpretations. Section 3 of the Acknowledgment of Receipt of Benefits, Subrogation Rights and Confidentiality Agreement constitutes the subrogation, in effect the "assignment," of all claims, causes of action, rights and recoveries to MHHS. *See Ulico Cas. Co. v. Clover Capital Mgmt., Inc.*, 146 F. Supp. 2d 163, 169 (ND NY 2001). Thus, because the Atteberrys accepted Plan benefits and acknowledged MHHS' right to prosecute their subrogation claims, MHHS owns the Atteberrys' subrogation claims and may settle the claims on the Atteberrys' behalf without their signature.

IV.

Based on the foregoing, IT IS HEREBY ORDERED that Memorial Hermann's Motion for Partial Summary Judgment **(Instrument No. 178)** is **GRANTED**.

The Clerk shall enter this Order and provide a copy to all parties.

SIGNED on this the 25th day of February, 2004, at Houston, Texas.

/s/ Vanessa D. Gilmore
VANESSA D. GILMORE
UNITED STATES
DISTRICT JUDGE

CAUSE NO. 62,827-C

MEMORIAL HERMANN HEALTHCARE SYSTEM AND MEMORIAL HERMANN HOSPITAL SYSTEMS	§	PROBATE COURT OF
vs.	§	
CAROL ANN PITTMAN, a.k.a. CAROL ANN PETERSON, Independent Executrix of the Estate of JOHN LINWOOD PITTMAN, JR., Deceased and Individually as beneficiary of the Estate of JOHN LINWOOD PITTMAN, JR., Deceased, JOHN LINWOOD PITTMAN, III, Individually as adult child and heir-at-law of JOHN LINWOOD PITTMAN, JR., Deceased, and JENNIFER LYNN PITTMAN, Individually as adult child and heir-at-law of JOHN LINWOOD PITTMAN, JR., Deceased	§	GALVESTON COUNTY, TEXAS

AGREED FINAL JUDGMENT

(Filed May 15, 2000)

ON THIS DAY, came Interpleader-Defendant, Carol Ann Pittman, a k a Carol Ann Peterson, Independent Executrix of the Estate of John Linwood Pittman, Jr., Deceased and Individually as Beneficiary of the Estate of John Linwood Pittman, Jr., Deceased, Interpleader-Plaintiffs, Memorial Hermann Healthcare System and Memorial Hermann Hospital Systems, and Interpleader-

Defendants, John L Pittman, III and Jennifer Pittman by and through their attorneys of record, and announced to the Court that the parties have entered into the following Final Agreed Judgment. It is therefore,

ORDERED, ADJUDGED AND DECREED that pursuant to the terms of Paragraph 8.2 of the Occupation Benefits Plan for The Employee of Memorial Hermann Healthcare System and Memorial Hermann Hospital System, the funds previously placed in the registry of the Court shall be paid to the personal representative of the Estate of John Linwood Pittman, Jr. Further, the Court finds that Carol Ann Pittman, a k a Carol Ann Peterson is the duly authorized personal representative of the Estate of John Linwood Pittman, Jr., and it is further

ORDERED, ADJUDGED AND DECREED that the Interpleader Plaintiffs, Memorial Hermann Healthcare System and Memorial Hermann Hospital Systems are hereby discharged from this Interpleader action, and that Interpleader Plaintiffs have voluntarily relinquished any request for attorney fees in prosecuting this Interpleader action, and it is further

ORDERED, ADJUDGED AND DECREED that all cross-claims, including cross-claims for declaratory judgment, and counter-claims are dismissed with prejudice; and it is further

ORDERED, ADJUDGED AND DECREED that any and all relief not specifically granted herein is denied

SIGNED this the 15th day of May, 2000.

/s/ Gladys B. Burwell
JUDGE PRESIDING

APPROVED AS TO FORM:

LORANCE & THOMPSON, P.C.

/s/ Phil Summers

Larry D. Thompson
TBN: 19930000
Phillip C. Summers
TBN: 19506600
2900 North Loop W., Suite 500
Houston, Texas 77092
(713) 868-5560
(713) 864-4671 (FAX)

Attorneys for Interpleader-Defendant, Carol Ann Pittman a.k.a. Carol Ann Peterson, Independent Executrix of the Estate of John Linwood Pittman, Jr., Deceased and Individually as Beneficiary of the Estate of John Linwood Pittman, Jr., Deceased

CRAIN, CATON & JAMES

/s/ [Illegible]

Helen B. Wils
TBN: 21665350
Sarah Patel Pachco
TBN: 00788164
Christopher A. Prine
TBN: 16329450
909 Fannin, Suite 3300
Houston, TX 77010-1079
713/658-2323
713/658-1921 fax

Attorneys for Interpleader-Defendants John L. Pittman, III and Jennifer Pittman

HANEN, ALEXANDER, JOHNSON &
SPALDING, L.L.P.

/s/ [Illegible]

Joseph R. Alexander, Jr.
TBN: 00995150
Craig A. Choate
TBN: 00790461
910 Travis Street, Suite 1700
Houston, TX 77002
713/222-2323
713/222-2226 fax

Attorneys for Interpleader-Plaintiffs, Memorial Hermann Healthcare System and Memorial Hermann Hospital Systems

No. 04-20349
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

CHARLES ATTEBERRY SR, ET AL,
Plaintiffs

v.

MEMORIAL-HERMANN HEALTHCARE SYSTEMS,
On Behalf and for the Benefit of The Estates,
Heirs, Devisees, Legatees, Spouses, Children
and/or Parents of Charles Atteberry Jr.,
Plaintiffs – Appellees

v.

MEMORIAL-HERMANN HEALTHCARE
SYSTEM; MEMORIAL-HERMANN HOSPITAL SYSTEM,
Plaintiffs - Appellants - Appellees

v.

BEN ETHRIDGE,
Intervenor - Plaintiff-Appellee

v.

DALINDA SHELTON; CAROL ANN PITTMAN,
also known as Carol Ann Peterson,
Independent Executrix of the Estate of
John Linwood Pittman, Jr., Deceased and
Individually as Beneficiary of
John Linwood Pittman, Jr.,
Intervenor - Plaintiffs - Appellants

v.

EUROCOPTER DEUTSCHLAND, GMBH, ET AL,
Defendants

Filed 5/3/2005

Appeals from the United States District Court
for the Southern District of Texas, Houston

ON PETITION FOR REHEARING EN BANC

Before GARWOOD, BENAVIDES, and STEWART, Circuit Judges. PER CURIAM:

Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (FED. R. APP. P. and 5TH CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

United States Circuit Judge

Judge Jones and Judge Clement did not participate in the consideration of the rehearing en banc.

29 U.S.C. § 1002. Definitions

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program –

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this Act providing one or more exempt categories under which –

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement,

shall, for purposes of this title, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this Act applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any

employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331-1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947, or the Railway Labor Act.

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan –

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of –

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.[,]

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise, which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of –

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate, is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of the Internal Revenue Code of 1986 [26 USC § 501(c)(22)] is permitted to make payments under section 4223 [29 USC § 1403] shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16)(A) The term "administrator" means –

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more

employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B [29 USCS §§ 1101 et seq.] means (A) in the case of a security for which there is a generally recognized market, either (i) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934 [15 USCS § 78f], or (ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and (B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which

arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 203 (a)(3) [29 USCS § 1053(a)(3)].

(20) The term "security" has the same meaning as such term has under section 2(1) of the Securities Act of 1933 (15 U.S.C. 77b(1)).

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B) [29 USCS § 1105(c)(1)(B)].

(B) If any money or other property of an employee benefit plan is invested in securities issued by an investment company registered under the Investment Company Act of 1940, such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed to be a fiduciary or a party in interest as those terms are defined in this title, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit

plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to –

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit.

For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 204(b)(1)(G) [29 USCS § 1054(b)(1)(G)].

(23) The term "accrued benefit" means –

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 204(c)(3) [29 USCS § 1054(c)(3)], expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account.

The accrued benefit of an employee shall not be less than the amount determined under section 204(c)(2)(B) [29 USCS § 1054(c)(2)(B)] with respect to the employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of –

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of –

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 402(a)(2) [29 USCS § 1102(a)(2)]) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value", with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficiaries over the present value of future contributions for the normal cost of all applicable plan participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost method which so provided, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of

the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (59 Stat. 669).

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501].

(B) The term "church plan" does not include a plan –

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of the Internal Revenue Code of 1986 [26 USCS § 513]), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph –

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes –

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan –

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7) of the Internal Revenue Code of 1986 [26 USCS § 72(m)(7)] at the time of such separation from service.

(D)(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] fails to meet one or more of the

requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years,

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this paragraph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means –

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default, whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provided for an individual account for each participant and for benefits based solely upon the amount contributed to the

participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provided a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant –

(A) for the purposes of section 202 [29 USCS § 1052], shall be treated as an individual account plan, and

(B) for the purposes of paragraph (23) of this section and section 204 [29 USCS § 1054], shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of the Internal Revenue Code of 1986 [26 USCS § 415] on plans to which that section applies, without regard to whether the plan is funded. To the extent that a separable part of a plan (as determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)(A) The term "multiemployer plan" means a plan –

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 4001(b)(1) [29 USCS § 1301(b)(1)] are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this title, notwithstanding the preceding provisions of this paragraph, for any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], the term "multiemployer plan" means a plan described in section 3(37) of this Act [para. (37) of this section] as in effect immediately before such date.

(E) Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 4403 [4303](b) and (c) [29 USCS § 1453(b) and (c)], that the plan shall not be treated as a multiemployer plan for

all purposes under this Act or the Internal Revenue Code of 1954 [26 USCS §§ 1 et seq.] if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980 –

(i) the plan was not a multiemployer plan because the plan was not a plan described in section 3(37)(A)(iii) of this Act [para. (37)(A)(iii) of this section] and section 414(f)(1)(C) of the Internal Revenue Code of 1954 [26 USCS § 414(f)(1)(C)] (as such provisions were in effect on the day before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980]); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)(i) For purposes of this title a qualified football coaches plan –

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of the Internal Revenue Code of 1986 [26 USCS § 401(k)(4)(B)], may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization –

(I) which is described in section 501(c) of such Code [26 USCS § 501(c)];

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year colleges or universities described in section 170(b) (1)(A)(ii) of such Code [26 USCS § 170(b)(1)(A)(ii)]; and

(III) which was in existence on September 18, 1986.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 402(a)(2) [29 USCS § 1102(a)(2)]) –

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who (i) is registered as an investment adviser under the Investment Advisers Act of 1940 [15 USCS §§ 80b-1 et seq.]; (ii) is not registered as an investment adviser under such Act by reason of paragraph (1) of section 203A(a) of such Act [15 USCS § 80b-3a(a)(1)], is registered as an investment adviser under the laws of the State (referred to in such paragraph (1)) in which it maintains its principal office and place of business, and, at the time the fiduciary last filed the registration form most recently filed by the fiduciary with such State in order to maintain the fiduciary's registration under the laws of such State, also filed a copy of such form with the Secretary; (iii) is a bank, as defined in that Act [15 USCS §§ 80b-1 et seq.]; or (iv) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained –

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative association.

(B) For purposes of this paragraph –

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b) [29 USCS § 1301(b)], except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

(iv) the term "rural electric cooperative" means –

(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 [26 USCS § 501(a)] and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(4) or (6)] which is exempt from tax under section 501(a) of such Code [26 USCS § 501(a)] and at least 80 percent of the members of which are organizations described in subclause (I), and

(v) the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(4) or (6)] which is exempt from tax under section 501(a) of such Code [26 USCS § 501(a)] and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(41) Single-employer plan. The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

[(42)](41) The term "single-employer plan" means a plan which is not a multiemployer plan.

Tex. Civ. Prac. & Rem. Code § **71.001** (2005)

§ 71.001. Definitions

In this subchapter:

(1) "Corporation" means a municipal, private, public, or quasi-public corporation other than a county or a common or independent school district.

(2) "Person" means an individual, association of individuals, joint-stock company, or corporation or a trustee or receiver of an individual, association of individuals, joint-stock company, or corporation.

(3) "Death" includes, for an individual who is an unborn child, the failure to be born alive.

(4) "Individual" includes an unborn child at every stage of gestation from fertilization until birth.

---

§ 71.002. Cause of Action

(a) An action for actual damages arising from an injury that causes an individual's death may be brought if liability exists under this section.

(b) A person is liable for damages arising from an injury that causes an individual's death if the injury was caused by the person's or his agent's or servant's wrongful act, neglect, carelessness, unskillfulness, or default.

(c) A person is liable for damages arising from an injury that causes an individual's death if:

(1) the person is a proprietor, owner, charterer, or hirer of an industrial or public utility plant or of a railroad, street railway, steamboat, stagecoach, or other vehicle for the transportation of goods or passengers; and

(2) the injury was caused by the person's or his agent's or servant's wrongful act, neglect, carelessness, unskillfulness, or default.

(d) A person is liable for damages arising from an injury that causes an individual's death if:

(1) the person is a receiver, trustee, or other person in charge of or in control of a railroad, street railway, steamboat, stagecoach, or other vehicle for the transportation of goods or passengers, of an industrial or public utility plant, or of other machinery; and

(2) the injury was caused by:

(A) the person's wrongful act, neglect, carelessness, unskillfulness, or default;

(B) the person's servant's or agent's wrongful act, neglect, carelessness, unfitness, unskillfulness, or default; or

(C) a bad or unsafe condition of the railroad, street railway, or other machinery under the person's control or operation.

(e) A person is liable for damages arising from an injury that causes an individual's death if:

(1) the person is a receiver, trustee, or other person in charge of or in control of a railroad, street railway, steamboat, stagecoach, or other vehicle for the transportation of goods or passengers, of an

industrial or public utility plant, or of other machinery; and

(2) the action could have been brought against the owner of the railroad, street railway, or other machinery if he had been acting as operator.

---

§ 71.003. Application; Certain Conduct Excepted

(a) This subchapter applies only if the individual injured would have been entitled to bring an action for the injury if the individual had lived or had been born alive.

(b) This subchapter applies whether the injury occurs inside or outside this state.

(c) This subchapter does not apply to a claim for the death of an individual who is an unborn child that is brought against:

(1) the mother of the unborn child;

(2) a physician or other licensed health care provider, if the death is the intended result of a lawful medical procedure performed by the physician or health care provider with the requisite consent;

(3) a person who dispenses or administers a drug in accordance with law, if the death is the result of the dispensation or administration of the drug; or

(4) a physician or other health care provider licensed in this state, if the death directly or indirectly is caused by, associated with, arises out of, or relates to a lawful medical or health care practice

or procedure of the physician or the health care provider.

---

§ 71.004. Benefitting From and Bringing Action

(a) An action to recover damages as provided by this subchapter is for the exclusive benefit of the surviving spouse, children, and parents of the deceased.

(b) The surviving spouse, children, and parents of the deceased may bring the action or one or more of those individuals may bring the action for the benefit of all.

(c) If none of the individuals entitled to bring an action have begun the action within three calendar months after the death of the injured individual, his executor or administrator shall bring and prosecute the action unless requested not to by all those individuals.

Tex. Civ. Prac. & Rem. Code § **71.021** (2005)

§ **71.021.** Survival of Cause of Action

(a) A cause of action for personal injury to the health, reputation, or person of an injured person does not abate because of the death of the injured person or because of the death of a person liable for the injury.

(b) A personal injury action survives to and in favor of the heirs, legal representatives, and estate of the injured person. The action survives against the liable person and the person's legal representatives.

(c) The suit may be instituted and prosecuted as if the liable person were alive.

Restatement of the Law, Third, Trusts
(Tentative Draft No. 4, April 5, 2005)

Part 6 – Trust Administration

Chapter 16 – Extent and Exercise of Trustees' Powers

§ **87** Judicial Control of Discretionary Powers

When a trustee has discretion with respect to the exercise of a power, its exercise is subject to supervision by a court only to prevent abuse of discretion.

COMMENTS & ILLUSTRATIONS: Comments:

a. Scope of Section; cross-references. A trustee generally has discretion (i.e., is to use fiduciary judgment) with respect to the exercise of the powers of the trusteeship. That is, a power is discretionary except to the extent its exercise is directed by the terms of the trust or compelled by the trustee's fiduciary duties. Even in cases of what are often called "mandatory" powers or provisions, for which trustee compliance is required except as provided in § 66 (equitable deviation in unanticipated circumstances), the trustee often has some discretionary authority and responsibility in important matters of implementation. For example, the terms of a trust may require the sale of certain real property but then, by failing to provide more, leave the trustee to exercise fiduciary judgment with respect to the timing (on which see § 92, Comment *b*), price, and other terms of the sale. Similarly, room for fiduciary judgment and responsibility may well remain in situations in which a trustee is directed to take action by the holder of a directory power (see § 75, Comment *b*, Illustration 1) or by the settlor of a revocable trust (§ 74, Comment *b*, Illustration 3).

The most important of the discretionary powers in most trusts are those having to do with various aspects of the investment function, together with, in many trusts, those having to do with discretionary distributions, such as a power to invade principal for an income beneficiary or the power to distribute income to a beneficiary or among a class of beneficiaries. These matters are dealt with in considerable detail in Chapter 17 (§§ 90-92, on "Investment of Trust Funds") and in § 50 ("Enforcement and Construction of Discretionary Interests"). See also Chapter 23 on discretionary powers in principal-income accounting. The rule of this Section and the principles described in its commentary apply not only to these matters but also to discretionary powers regarding other aspects of trust administration.

This Section applies to discretionary authority that is ordinarily implicit in the powers of trustees (supra) as well as to discretionary authority that is expressly stated in the terms of a trust. Express grants of discretion and accompanying language, however, often present issues of interpretation or effect, sometimes beginning with a question of whether a settlor's "grant" of discretion with regard to a power is merely redundant or confers a broader degree of authority than would normally be implicit in the particular power. See Comment *d*.

b. Judicial review and control of trustee's discretion. When judicial intervention is required, the court may (ordinarily upon petition by a beneficiary) assert control over the exercise of a discretionary power by directing the trustee to act or refrain from acting or by setting aside a transaction in which the trustee has already acted. Or the court may hold the trustee liable for the adverse consequences of improper conduct, as in other breaches of

fiduciary duty. The court may also, or instead: issue instructions clarifying the trustee's duties in exercising the discretionary power (cf. § 71) or otherwise establish safeguards against future abuse; deny or diminish the trustee's compensation; or even remove the trustee if there has been repeated or serious abuse of the discretionary power (see § 37, Comments *e* and *g*). Further discussion of remedies is beyond the scope of this Section, but see Chapters 18 (especially § 95) and 19; also see § 50, Comment *b*.

A court will not interfere with a trustee's exercise of a discretionary power (including a decision not to exercise the power) when that exercise is reasonable, not based on an improper interpretation of the terms of the trust, and not otherwise inconsistent with the trustee's fiduciary duties (see particularly §§ 76-79). Thus, judicial intervention is not warranted merely because the court would have differently exercised the discretion.

On the other hand, a court may be called upon to intervene for the purpose of preventing a trustee's abuse (including by misinterpretation) of discretionary authority. What constitutes an abuse of discretion depends on the terms and purposes of the trust, and particularly on the terms and purposes of the power and any standards or guidance provided for its exercise, as well as on applicable principles of fiduciary duty. See Comment *c*. Also relevant is the extent of the discretion conferred upon the trustee. See Comment *d*.

c. Abuse of discretion: in general. An abuse of discretion may result from the exercise of discretionary authority in bad faith or from improper motive. Thus, a discretionary power is abused if a trustee acts dishonestly, such as when

the trustee receives an improper inducement for exercising the power in question. Similarly, an abuse of discretion occurs when a trustee acts from an improper even though not dishonest motive, such as when the act is undertaken in good faith but for a purpose other than to further the purposes of the trust or, more specifically, the purposes for which the power was granted. See, e.g., § 50, Comment *b(2)*, that a discretionary power to make distributions for a beneficiary's "support" does not permit the trustee to make well-intentioned, even otherwise reasonable, distributions that are not support-related.

When the exercise of a discretionary power is left to the judgment of a trustee, an abuse of discretion may result from the trustee's improper failure to exercise that judgment. An abuse of this type results if the trustee, arbitrarily or without knowledge of or inquiry into relevant circumstances, fails to exercise the discretion. So also, the court will interpose where a trustee fails to exercise or otherwise abuses discretionary authority because of mistaken interpretation of the terms of the trust or misunderstanding of fiduciary law.

Perhaps most of the litigation in which it is concluded that a trustee has committed an abuse of discretion involves a finding that the trustee, in exercising a power, has acted unreasonably – that is, beyond the bounds of a reasonable judgment. In some cases there is an objective standard by which the reasonableness of the trustee's conduct can be measured, but expressed standards are not necessary in order for a good-faith decision of a trustee to be found unreasonable; a court may apply what has sometimes been called "a general standard of reasonableness," taking account of other terms and purposes of the trust. In either event, judicial intervention on the ground of abuse is

called for, not because the court would have exercised the discretion differently, but because the trustee's decision is one that would not be accepted as reasonable by persons of prudence. Thus, a court may properly interpose if it finds that the trustee's conduct, in exercising a discretionary power, fails to satisfy the applicable standard of care and skill (§ 77).

For example, if discretionary power is conferred upon a designated trustee to appoint a successor or additional trustee, and the designated trustee appoints an unfit person, the court will remove the person so appointed.

Other common examples, and many reported cases, of allegedly unreasonable or otherwise abusive exercise of discretion involve either investment management (see commentary and illustrations in §§ 90-92, and Reporters Notes thereto) or discretionary distributions to beneficiaries (see commentary and illustrations in § 50, and Reporter's Note thereto).

Illustrations:

1. The corpus of S's revocable trust passed on her death to T, as her successor trustee, to pay the trust income to S's daughter D during her lifetime, remainder thereafter to go by right of representation to the issue of D who survive her. The terms directed T to sell the real property that had served as S's home and to reinvest the proceeds, "unless T, in his discretion, decides to retain that property for D's use as her residence, which T is hereby authorized to do if and for as long as he believes this to be an appropriate and reasonable use of that property." Shortly after S's death, T received and accepted an offer from P to purchase that residential property (upon terms

that no one challenges as unsatisfactory or imprudent if a sale is to made); but T had made no effort to ascertain D's interest or personal or financial circumstances, or otherwise to investigate or consider whether her use of the property as a residence would be "appropriate and reasonable." By failing to exercise his judgment, T has abused his discretionary power regarding retention of the residential property for D's benefit.

2. The same facts as in Illustration 1, except that in the years between S's creation of the revocable trust and her death, D's husband died and her children became adults, left home, and married. T exercised his judgment, deciding that the residential property was not appropriate to D's needs and circumstances and also finding that D had no desire for the property to be retained for her use. Upon inquiry and investigation, T reached the further conclusion that the residential property would be just right for one of D's sons and his growing family. T therefore decided that the property should be retained and entered into a rental agreement with the son, setting a reasonable rent that could be paid to D as trust income. Absent other facts (e.g., showing grounds for equitable deviation under § 66), T has abused his discretion, even if in good faith, by exercising it for an improper motive – that is, for a purpose other than that for which he was granted discretionary power to retain the property, rather than sell it as otherwise directed.

d. Extended discretion: limitations, interpretation, and effects. Ordinarily, a mere grant of discretion in the terms of the trust, or an express reference to the discretionary character of a power or of powers generally, does not authorize the trustee to act beyond the bounds of reasonable

judgment. See, e.g., discussion in § 90, Comments *g-g(2)*. A settlor may, however, manifest an intention to grant greater than ordinary latitude in the trustee's exercise of discretionary judgment.

Once it is determined that the power in question is held in the role of trustee, words such as "absolute" or "sole and uncontrolled" or "unlimited" are not interpreted literally. It is contrary to sound policy, and a contradiction in terms, to permit the settlor to relieve a *trustee* of all accountability. See § 50, Comment *a*, and cf. § 75, Comment *c*. Even under the broadest grant of fiduciary discretion, a trustee must act honestly and (as cases have sometimes quoted from prior Restatements) "in a state of mind contemplated by the settlor." What this means is that courts will intervene to prevent trustees from acting in bad faith or without regard to the terms and purposes of the trust and the interests of its beneficiaries, or for some purpose or motive other than the accomplishment of the purposes of the discretionary power. Except to the extent the power is for the personal benefit of a beneficiary-trustee, the court may also be called upon to prevent the trustee from failing to act, whether capriciously, arbitrarily, or from a misunderstanding of the trustee's powers or duties.

Within these limits, it is a matter of interpretation to determine the degree to which a settlor's use of language of extended discretion (e.g., "absolute discretion") manifests an intention to modify the normal duties of the trustee and the normal grounds of judicial intervention in the exercise of a discretionary power. A primary question is whether and to what extent the settlor's language may authorize the trustee to act beyond the bounds of what would otherwise be a reasonable judgment.

Examination of the overall tenor of language granting powers and other terms of trusts may lead to diverse, refined interpretations on a case-by-case basis. For example, a court may conclude that the language of extended discretion and other evidence before it manifests a settlor intention to authorize the particular trustee to act with a lesser degree of *caution* (e.g. to accept a greater degree compensated risk), but not a lesser degree of *care*, than would otherwise be appropriate to the particular trust and its circumstances under the duty of prudence (§ 77). Cf., in the investment context, § 91, Comment *g(1)*, and § 90, Comment *g*. Similarly, on the possibility of a "one-sided" liberalization of discretionary authority with regard to distributions (and on likely reasons for granting extended discretion), see § 50, Comment *c* (text following Illustrations 3 and 4).

Illustrations:

3. The same facts as in Illustration 2 (in Comment *c*, above), except that the quoted terms of the trust began "unless T, in his absolute discretion, decides to retain. . . . " The addition of the word "absolute" would not affect the result stated in Illustration 2, because T is still not authorized to retain the property for a purpose other than that for which the extended discretion was granted.

4. The same facts as in Illustration 3, above, except that the language there quoted continues by allowing T to retain "that property for a beneficiary's use as a residence, which T is authorized to do if, and for so long and upon such terms as, T believes appropriate and reasonable." T's actions in retaining the property and in leasing it to D's son are within the range of the authorized

discretion (and would appear to be so even without the *extended* discretion).

5. The same trust as in the foregoing Illustrations (essentially, a trust for D for life, remainder to her issue who survive her), except that the terms of the trust grant T "absolute and binding discretion, in the event of any controversy or uncertainty, to construe and finally determine the meaning of the trust provisions." Upon the death of D, T distributes the corpus in three equal shares to D's two then surviving children and the surviving spouse of D's other child, who died shortly before D. This is an abuse even of T's extended discretion, there being no "uncertainty" in (or reasonable grounds for "controversy" over) a disposition (Illustration 1 wording) "to the issue of D who survive her" that would justify a construction including the spouse of a deceased child. (Such a broad grant of discretion, however, should ordinarily be interpreted as allowing T to so construe the remainder to D's "issue" as to include her deceased child's adopted or nonmarital child, even if such a traditionally troublesome question of construction would, at the time, have been subject to a different presumption under applicable case law or statutory rule of construction.)

With grants of extended discretion, contrast § 96 on exculpation clauses. An exculpatory provision is not intended to broaden the authority of the trustee, or to encourage or authorize breach of trust, or even to narrow the *grounds* of judicial intervention, but to relieve the trustee of liability (to the extent provided in the clause and allowed by law) should a breach of trust occur.

REPORTERS NOTES: REPORTER'S NOTES ON § 87

The earlier counterpart of the material in this Section was Restatement Second, Trusts § 187. The principles stated here are consistent with those of the earlier edition except for the narrow variation indicated in the Reporter's Note to Comment *d*. The present Section is relatively brief due to the elaborate treatment of discretionary distribution provisions in § 50 (which had only a modest counterpart in the commentary of prior § 128) and the extensive treatment of discretion in investment matters in §§ 90-92; also see consideration of discretionary powers regarding principal-income accounting in Chapter 23.

See also III William F. Fratcher, *Scott on Trusts* §§ 187-187.5 (4th ed. 1988); and George G. Bogert & George T. Bogert, *The Law of Trusts and Trustees* § 560 (Rev. 2d ed., 1980), and cf. id., § 552.

Comment *a*:

In criticizing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989) (an ERISA case), J. Langbein, "The Supreme Court Flunks Trusts," 1990 Supreme Ct. Rev. 207 (1991), stated (at 219): "This distinction between trust powers that derive from the background law of trusts, and those that derive from the trust instrument, is fundamentally mistaken. It is refuted in the very source that the Court treats as authoritative, section 187 of the Restatement [Second] of Trusts. Official Comment *a* to section 187 says: ' . . . The exercise of a power is discretionary except to the extent to which its exercise is required by the terms of the trust or by the principles of law applicable to the duties of trustees.' In other words, discretion does not depend upon an explicit grant in the instrument. The trustee has discretion unless

the instrument or some particular doctrine of trust law denies discretion. Discretion is the norm."

The power trustees have to maintain lawsuits is discretionary and not to be interfered with by courts at the instance of beneficiaries without a showing of abuse. Matter of Geffen's Estate, 25 Misc. 2d 734, 202 N.Y.S.2d 599 (Sur. Ct. 1960). But where a trust purpose is to sell trust realty, despite a trustee's discretion regarding timing, an allegation of unreasonable delay in the selling is not demurrable. Hawkins v. Tanner, 243 Ala. 641, 11 So.2d 351 (1943).

That an express grant of simple "discretion" in the terms of the trust is ordinarily to be construed as granting the trustee no wider latitude than is already conferred by the prudent investor rule (which itself authorizes flexible, discretionary asset management), but that the settlor's use of that term is likely to expand the authority of a trustee who would otherwise be subject to a more restrictive statutory or common-law body of default rules, see § 91, Comments *c-c(2)*, and illustrations in id. Comment *c(3)*.

Comments *b* and *c*:

For a few of the cases citing or quoting prior Restatement provisions similar to those in Comments *b* and *c* of this Section, see Moench v. Robertson, 62 F.3d 553 (3d Cir. 1995), cert. denied, 516 U.S. 1115 (1996) noted 58 U. of Pittsburgh L. Rev. 255 (1996), and 49 Rutgers L. Rev. 1231 (1997); and Raffety v. Parker, 241 F.2d 594 (8th Cir. 1957); In re Trust Estate of Wills, 8 Ariz. App. 591, 448 P.2d 435 (1968); Takabuki v. Ching, 695 P.2d 319 (Haw. 1985); Johnson v. Johnson, 242 Iowa 27, 45 N.W.2d 573 (1951) (power of sale), noted 6 Arkansas L. Rev. 78; Jennings v.

Murdock, 220 Kan. 182, 553 P.2d 846 (1976); Boston Safe Deposit & Trust Co. v. Stone, 348 Mass. 345, 203 N.E.2d 547 (1964) (power to fix values); United States v. O'Shaughnessy, 517 N.W.2d 574 (Minn. 1994); Yeates v. Box, 198 Miss. 602, 20 So.2d 411 (1945) (power to terminate trust); Matter of Heisserer, 797 S.W.2d 864 (Mo. App. 1990); In re Frances M. Johnson Trust, 211 Neb. 750, 320 N.W.2d 466 (1982); Hanford v. Clancy, 87 N.H. 458, 183 A. 271 (1936); Matter of Roberts, 61 N.Y.2d 782, 461 N.E.2d 300, 473 N.Y.S.2d 163 (1984); Little v. Wachovia Bank & Trust Co. 252 N.C. 229, 113 S.E.2d 689 (1960) (principal-income allocation power); Geron v. Kennedy, 381 Pa. 97, 112 A.2d 181 (1955); Krug v. Krug, 838 S.W.2d 191 (Tenn. App. 1992) (power to remove and replace co-trustee), appeal denied, 838 S.W.2d 197 (Tenn. 1992); Austin v. U.S. Bank, 73 Wash. App. 293, 869 P.2d 404 (1994), review denied, 124 Wash. 2d 1015, 880 P.2d 1005 (1994); and Estate of Filzen, 252 Wis. 322, 31 N.W.2d 520 (1948) (discretion to terminate).

See generally *Scott on Trusts*, supra, § 187:

> . . . The court will not control [a trustee's] exercise of [discretion] as long as he does not exceed the limits of the discretion conferred upon him. The court will not substitute its own judgment for his. Even where the trustee has discretion, however, the court will not permit him to abuse the discretion. This ordinarily means that so long as he acts not only in good faith and from proper motives, but also within the bounds of a reasonable judgment, the court will not interfere; but the court will interfere when he acts outside the bounds of a reasonable judgment. In other words, although there is a field, often a wide field, within which the trustee may determine whether

> to act or not and when and how to act, beyond that field the court will control him. How wide that field is depends upon the terms of the trust, the nature of the power, and all the circumstances. . . .
>
> In determining whether the trustee in exercising or refraining from exercising a power is abusing the discretion conferred upon him, much depends of course upon the extent of the discretion intended by the settlor to be conferred upon him . . . [and] upon whether there was any standard by which the trustee's conduct can be judged. . . .

Compare Bogert & Bogert, supra, § 560 (pp. 194-195, 207):

> Clearly, if the trustee who has the discretionary power has failed or refused to exercise that power or to consider its use, the court may compel him to review the question of whether to exercise the power in light of all surrounding circumstances and to make some decision. . . . [P]So also, if the trustee has gone through the formality of using his discretion but has not deliberately considered the arguments pro and con, and has thus made a decision for no reason at all, his conduct can be characterized as arbitrary and capricious, . . . [and] as not in performance of his duty in regard to the discretionary power. . . . [P]On the other hand, a trustee who is authorized to retain oil investments will not be subjected to court intervention with his discretion if he has acted honestly, even though the securities are returning a very small income and many trustees would have sold them.

That, absent any standards in the terms of the trust for the trustee's (and court's) guidance, a court will require a trustee to follow a general standard of reasonableness in

exercising a discretionary power, see, e.g., Rowe v. Rowe, 219 Ore. 599, 347 P.2d 968 (1959); and Rinker's Adm'r. v. Simpson, 159 Va. 612, 166 S.E. 546 (1932) (clear standard or guide in terms of power not essential to finding good-faith decision so unreasonable as to constitute an abuse of discretion under language "as [trustee] deems best"), noted in 81 U. of Pennsylvania L. Rev. 1008 (1933).

Various aspects of a trustees' judgments in the maintenance and general management of a farm were challenged in Goodwine v. Goodwine, 819 N.E.2d 824 (Ind. App. 2004), but the trial and appellate courts found that the trustees had not acted in an unreasonable manner that would constitute an abuse of their discretion. But in Alexander v. Nelson, 825 S.W.2d 106 (Tenn. App. 1991), the court held it improper for the trustee to sell property to a child of the testator for a price significantly below its market value, despite a trust provision granting power to sell trust property to children of the settlor for a "price and upon such terms as [the trustee] thinks best" (cf. § 79(1) on impartiality); and cf. Keeler v. Lauer, 73 Kan. 388, 85 P. 541 (1906), that a trust provision relieving the trustee of any duty to report to a court did not relieve the trustee from accountability in court for mismanagement.

In re Watland, 211 Minn. 84, 300 N.W. 195 (1941), found it unreasonable, and an abuse of discretion, for the trustee to allocate to income the *proceeds* of the sale of trust securities. Also, on discretionary powers to make allocations between income and principal, compare In re Clarenbach's Trust, 23 Wis. 71, 126 N.W.2d 614 (1964), with the much-cited case of Dumaine v. Dumaine, 301 Mass. 214, 16 N.E.2d 625 (1938), 118 A.L.R. 834; both cases involved discretionary allocation of capital gains. See also oft-cited Old Colony Trust Co. v. Silliman, 352 Mass. 6, 223 N.E.2d

504 (1967). And see Gimbel v. B.F. & A.B. Gimbel Foundation, 95 N.J. Super. 418, 231 A.2d 389 (1974) (discretionary principal-income power not to be used to alter substantially the value of the interests of the income and remainder beneficiaries); Comment, "Principal and Income: The Discretionary Allocation Clause," 30 Baylor L. Rev. 343 (1978); and compare 1997 Revised Uniform Principal and Income Act § 2 that "no inference of imprudence or partiality arises from the fact that a trustee" with discretionary authority "has made an allocation contrary to the provisions of this Act." On the possible adverse effects of extended discretion regarding principal-income accounting, see Samuel P. Hunt Trust v. U.S., 93 A.F.T.R.2d 351 (D. N.H. 2004) (gains not permanently set aside for charity).

A court found an abuse of discretion in Thomas v. Wood, 228 Ga. 206, 184 S.E.2d 561 (1971), in a situation in which a trustee, having broad power to manage trust property as he deemed appropriate, paid off a loan amount in excess of the amount of the lien against trust realty even though the testatrix (settlor) had no personal liability on the loan.

In Benadom v. Colby, 81 Md. App. 222, 567 A.2d 463 (1989), the court construed a provision in the trust agreement as granting the trustees power to interpret the trust's dispositive provisions, and therefore held that the trial court had erred by not deferring to the trustees' interpretation of the distributive provision in question. Compare Bogert & Bogert, supra, § 559 (p. 169): "Although the settlor may give the trustee power to construe the trust instrument in case of dispute or doubt, the trustee's decision will be subject to review by the court as to its reasonableness."

"Discretion is the touchstone of trusteeship, and we invade the province of the trustee only when he violates the proper exercise of his discretion." Lowry v. Bankers Life & Casualty Retirement Plan, 865 F.2d 692, 694 (5th Cir. 1989) (ERISA case). And see (another ERISA case) Exbom v. Central States Welfare Fund, 900 F.2d 1138, 1142 (7th Cir. 1990): "Under the common law courts will not review the discretionary decisions of trustees and other fiduciaries *de novo*, but will look only for the trustee's abuse of its discretionary authority."

For an example of judicial intervention based on a trustee's misinterpretation of trust terms, see Griffin v. Griffin, 463 So.2d 569 (Fla. App. 1985).

For an example of court intervention for nonexercise of discretion, see Clark v. Mississippi Valley Trust Co., 357 Mo. 785, 211 S.W.2d 10 (1948). Cf. Matter of Osborn, 252 App. Div. 438, 299 N.Y.S. 593 (1937) (trustee responding to demands of a beneficiary without exercise of independent judgment); and Jacob v. Davis, 128 Md. App. 433, 738 A.2d 904 (1999), cert. denied 357 Md. 482, 75 A.2d 436 (2000).

For an example of the removal of a trustee for favoring one beneficiary over others in exercising discretion (see § 79 on duty of impartiality), see Jones v. Jones, 8 Misc. 660, 30 N.Y.S. 177 (1894); and cf. Wiggins v. PNC Bank, 988 S.W.2d 498 (Ky. App. 1998).

For an example of judicial intervention on behalf of persons holding support judgments against the beneficiary of a discretionary spendthrift trust, based on the trustee's abuse of his discretion by withholding discretionary distributions, see Ventura County Dept. of Child Support Services v. Brown, 116 Cal. App. 4th 144, 11 Cal. Rptr. 3d

489 (2004). Cf. § 60, Comment *c*, and also (on spendthrift exception) § 59, Comment *b*.

For a refusal to intervene, finding no abuse of discretion or other breach of fiduciary duty, where it was alleged that the trustees (in exercising their broad discretion to amend the trust) had violated their duties to plaintiff by modifying the trust to eliminate her beneficial interest, see Rubinson v. Rubinson, 250 Ill. App. 3d 206, 620 N.E.2d 1271, 190 Ill. Dec. 10 (1993) (the court concluding that the trustees' action was consistent with the settlor's intention in granting the power).

Comment *d*:

Policy limits on settlor's grant of extended discretion. In Carrier v. Carrier, 226 N.Y. 114, 125, 123 N.E. 135, 138 (1919), the opinion (Cardozo, J.) acknowledged that the trustee had very broad management powers and that his discretion was to be "absolute and uncontrolled" but stated that this does not mean "that it might be recklessly or willfully abused," adding: "He had made himself a trustee; and in so doing had subjected himself to those obligations of fidelity and diligence that attached to the office of trustee." And the court in Keating v. Keating, 182 Iowa 1056, 1069, 165 N.W. 74, 77-78 (1917), stated: "We think . . . that no trust has been or can be created in property where the discretion of the trustee is so broad or illimitable that equity will not entertain a complaint by the beneficiary that the trust has been or is being abused, or that the property is being wrongfully diverted to the destruction or defeat of the purpose for which the founder established it. . . . And we think if the devise in this case were to be construed in accordance with the defendant's

theory as being intended to give him absolute and uncontrolled discretion independent of any authority in the court to control its arbitrary exercise, it would have to be held, to that extent, void."

Compare Armitage v. Nurse, [1998] Ch. 241 (CA), in which Millot, L.J., stated (at 253-254): "There is an irreducible core of obligations owed by the trustees to the beneficiaries and enforceable by them which is fundamental to the concept of a trust. If the beneficiaries have no rights enforceable against the trustees there are no trusts. . . . The duty of the trustees to perform the trusts honestly and in good faith for the benefit of the beneficiaries is the minimum necessary to give substance to the trusts. . . . "

Effect and construction *of language of extended discretion.* Comment *j* of Restatement Second, Trusts § 187 states that the settlor may manifest an intention "that the trustee's judgment need not be exercised reasonably, even when there is a standard by which the reasonableness of the trustee's conduct can be judged." The Comment continues: "This may be indicated by a provision in the trust instrument that the trustee shall have 'absolute' or 'unlimited' or 'uncontrolled' discretion" – language that is "ordinarily construed as merely dispensing with the standard of reasonableness" so that "the mere fact that the trustee has acted beyond the bounds of a reasonable judgment is not a sufficient ground for interposition by the court." The Comment adds, however: "The court will interfere if the trustee acts in a state of mind not contemplated by the settlor. Thus, the trustee will not be permitted to act dishonestly, or for some motive other than the accomplishment of the purposes of the trust, or ordinarily to act arbitrarily without an exercise of his judgment." Id., Comment *k* ("*Limits of power of settlor to confer discretion*")

further observes that, if a trust is created, it is "against public policy to permit the settlor to relieve the trustee of all accountability."

Although the commentary here (to present § 87) does not foreclose the possibility of an interpretation that dispenses with the requirement of "reasonableness," it does not follow Trusts Second in its recognition of that result as the ordinary construction of typical language of extended discretion (i.e., "absolute," "sole and uncontrolled," and the like), because that construction neither seems routinely appropriate nor does case authority actually support that generalization. It is difficult to find cases in which the court has upheld an exercise of discretion that, in the circumstances, truly appears to have been *unreasonable*. Compare the segment specially entitled "Update: Absolute or Uncontrolled Discretionary Powers of Trustees" in the 2003 Supplement to § 560 of Bogert & Bogert, supra: "In many cases it would appear that the same result is reached regardless of which standard [i.e., extended or simple discretion] is applied by the court. . . . There is agreement that a trustee must act in good faith and without an improper motive, and that a trustee must not act arbitrarily or capriciously, that is, without any exercise of his judgment. . . . All courts probably would agree that the trustee's absolute discretion cannot be exercised to defeat the settlor's intent or the trust purposes. . . . [P]Sometimes the trustee is given the power to invest in his absolute and uncontrolled discretion; in several recent cases the court found that . . . the grant of discretion did not protect the trustee from liability for imprudent investments. Where the trustee is granted broad discretion in making allocations of receipts and disbursements to the principal and income accounts, some courts have held that

the trustee nevertheless must follow the applicable principal and income statute, while other courts have given effect to the grants of discretion by construing that they authorize the trustee to deviate from established principal and income law, although holding that the exercise of discretion remains subject to the standards of reasonableness and good faith and that an exercise of the power must not defeat the settlor's intent or the trust purposes. . . . [P]It would appear that the difference in the attitude of the courts toward 'simple' discretionary powers, on the one hand, and 'absolute' or 'uncontrolled' discretionary powers, on the other hand, is one of degree rather than of kind. The courts appear more likely to find an abuse of a simple discretionary power than an abuse of an absolute or uncontrolled discretionary power. . . . " The original version (of rev. 2d ed., 1980) of Bogert & Bogert, supra, § 560 (after quoting from a couple of leading cases (also quoted, supra this Note) on the limits of discretion), expressed some doubt about the Restatement Second position and stated essentially (at 213-215) that the difference between extended and simple discretion is one of degree more than of kind, noting that even an "absolute discretionary power must not be used in a 'extravagantly unreasonable' or 'arbitrary' manner . . . or for a purpose other than a trust purpose" and then further observing (at 220-221) that it "may be concluded" that courts "are more easily persuaded to find an abuse of a mere discretionary power than to find an improper use of an absolute or uncontrolled power."

A case that at least appears supportive of the Restatement Second position is In re Koos' Estate, 269 Wis. 479, 69 N.W.2d 598 (1955), in which the trustees were granted "absolute discretion" in exercising their power to sell

certain securities; upon challenge to their exercise of the power of sale, the court refused to interfere or surcharge the trustees in the absence of a showing of fraud, arbitrary action, or bad faith because the trustees' discretionary action need not conform to a standard of reasonableness, quoting at length (id. at 492, 69 N.W.2d at 606) from Restatement Second, Trusts § 187, Comment *j*. And cf. Matter of Fleet Trust Co., 262 App. Div. 2d 935, 692 N.Y.S.2d 548 (1999). (The trustees' decision in neither case, however, would seem likely to shock an observer on the lookout for unreasonable fiduciary behavior.)

Illustration 5. In Taylor v. McClave, 128 N.J. Eq. 109, 15 A.2d 213 (1940), the trust terms granted the trustees power to construe the instrument in case of dispute or doubt and provided that their determinations of its meaning were to be final, but the court concluded that this did not preclude intervention when a construction is erroneous, because a court's equitable powers cannot be eliminated by trust provision. Compare, in England, Re Wynn's Will Trusts, [1952] 1 All Eng. Rep. 341 (grant of absolute discretion, to be binding on all beneficiaries, to resolve all questions and matters of doubt in administering the trust; contrary to public policy as an attempt to oust the court from its equitable jurisdiction).

Also on Illustration 5, see Benadom v. Colby, 81 Md. App. 222, 567 A.2d (1989), and Bogert & Bogert, super, § 559 (p. 169), both of which are discussed (or quoted) near the end of the Reporter's Note to Comments *b* and *c*, above. But compare Old National Bank & Trust Co. v. Hughes, 16 Wash. 2d 584, 134 P.2d 63 (1943), in which a trustee's discretionary power to determine the trust beneficiaries was upheld when there was no showing of arbitrary or dishonest conduct.

The trustees in In re Teasdale's Estate, 261 Wis. 248, 52 N.W.2d 366 (1952), were given discretionary power, to be conclusive, final and not reviewable, to establish the value of the settlor's estate at death in order to determine the extent of his widow's beneficial interest; but the court concluded that the valuations determined by the trustees (one of whom was the widow) should be set aside and proper values substituted because the trustees' values were unduly favorable to the widow and not reached in good faith (thus, certainly in violation of the duty of impartiality). Cf. Matter of Bruches, 67 App. Div. 2d 456, 415 N.Y.S.2d 664 (1979).

See also Estate of Hansen, 344 Pa. 12, 15, 23 A.2d 886, 887 (1942) (valuation at inventory values instead of market values rejected despite trustees' power to value securities, upon receipt, at what the trustees consider to be a fair and equitable amount): "No matter how broad the discretion granted, equity will interfere to prevent its exercise in a manner that would frustrate the true intent and purpose of the testatrix."

For examples of nonexercise of discretion, see In re Murray, 142 Me. 24, 45 A.2d 636 (1946), and Coberly v. Superior Court, 231 Cal. App. 2d 685, 42 Cal. Rptr. (1965). And see Conway v. Emeny, 139 Conn. 612, 96 A.2d 221 (1953), which found an abuse and issued an injunction to prevent the trustees of a museum from implementing their decision to close the museum as they were empowered to do if in their "absolute discretion" they determined there was insufficient public interest to warrant its continuance, with the result that the trust funds would pass to another charitable trust that was founded by the same settlor and had great need for additional funds; the trustees had abused their extended discretion by voting to close the

museum without actual consideration of the public interest in it.

Just as an exculpatory clause does not broaden the trustee's authority (last paragraph of Comment), a trustee's "wide discretion" did not serve "as exculpatory of the liability of a trustee" for imprudent exercise of a discretionary power in McNeil v. McNeil, 798 A.2d 503, 509 (Del. 2002).

Restatement of the Law, Second, Trusts, § 183

§ **183** Duty to Deal Impartially with Beneficiaries [as Revised]

When there are two or more beneficiaries of a trust, the trustee is under a duty to deal impartially with them.

COMMENTS & ILLUSTRATIONS: Comment:

a. Applicability of Section. The rule stated in this Section is applicable whether the beneficiaries' interests in the trust property are concurrent or successive.

By the terms of the trust the trustee may have discretion to favor one or more beneficiaries over others. The court will not control the exercise of such discretion, except to prevent the trustee from abusing it. See § 187.

On successive beneficiaries generally, see §§ 232-241. On the duty of impartiality in matters of investment caution and productivity, see § 227, Comments *e* and *i*.

Mayer, Day, Caldwell & Keeton, L.L.P.

SUMMARY PLAN DESCRIPTION OF THE OCCUPATIONAL BENEFITS PLAN FOR THE EMPLOYEES OF MEMORIAL HERMANN HEALTHCARE SYSTEM

(As Amended and Restated Effective March 1, 1998)

(Filed Dec. 21, 1999)

* *

Este librete contiene un sumario en inglés de sus derechos y beneficios bajo el Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare System (el "Plan"). Si encuentra dificultad en comprender cualquier parte de este librete por favor comgase en contacto con la oficina de personnel, 7737 Southwest Freeway, Suite 415, Houston, Texas 77074. La oficina está abierta de las 8:30 hasta las 17:00 horas, de lunes a viernies. Si desea puede liamar la oficina, (713) 776-5664, para que le asistan con sus preguntas.

* *

TABLE OF CONTENTS

		Page
INTRODUCTION		iv
FOREWORD		vi
ARTICLE I.	OVERVIEW	1
ARTICLE II.	DEFINITIONS	1
2.1.	Accident	1
2.2.	Active Service	1
2.3.	Administrative Committee	2
2.4.	Administrator	2
2.5.	Benefits	2
2.6.	Board	2
2.7.	Bodily Injury	2
2.8.	Cumulative Trauma	2
2.9.	Death	3
2.10.	Determination	3
2.11.	Disease	3
2.12.	Dismemberment	3
2.13.	Eligible Employee	3
2.14.	Eligible Expense	3
2.15.	Emergency Medical Care	4
2.16.	Employee	4
2.17.	Employer	4
2.18.	ERISA	4
2.19.	Excluded Medical Expense	5
2.20.	Health Care Facility	5

2.21. Home Health Care Agency 6
2.22. Hospital 6
2.23. Incident Report 6
2.24. Medical Records 6
2.25. Medically Necessary 6
2.26. Occupational 7
2.27. Other Occupation 7
2.28. Partial Disability 7
2.29. Physician 7
2.30. Plan 7
2.31. Plan Administrator 7
2.32. Plan Sponsor 8
2.33. Plan Year 8
2.34. Pre-Existing Condition 8
2.35. Preferred Provider 8
2.36. Proof of Loss 8
2.37. Rehabilitation 8
2.38. Skilled Nursing Facility 8
2.39. Third Party Administrator 9
2.40. Total Disability 9
2.41. Usual and Customary Charge 9
2.42. Wage Continuance 9
ARTICLE III. ELIGIBILITY 9
3.1. Commencement 9
3.2. Cessation 10
3.3. Reinstatement 10

3.4. Continuation of Benefits 10
3.5. Eligibility Limited to Periods Of Active Service 10
3.6. Non-Discrimination 10
ARTICLE IV. INCIDENT REPORTING AND INVESTIGATION 10
4.1. Employee's Responsibilities 10
4.2. Employees Responsibilities 11
ARTICLE V. DRUG AND ALCOHOL TESTING 12
ARTICLE VI. RELEASES 12
ARTICLE VII. APPROVED MEDICAL PROVIDERS 12
ARTICLE VIII. BENEFIT AWARDS 13
8.1. Administrative Committee Review 13
8.2. Death or Dismemberment; Schedule of Benefits 14
8.3. Wage Continuance 14
8.4. Maximum Benefits 16
ARTICLE IX. EXCLUSIONS FROM COVERAGE ... 17
ARTICLE X. COMMENCEMENT OF BENEFITS ... 20
ARTICLE XI. SUBROGATION 20
11.1. Plan's Right of Subrogation 20
11.2. Employee's Agreement To Subrogation 20
11.3. Limitation To Plan's Subrogation Rights 21
11.4. Subrogation Rights Not Affected By Payment 21
11.5. Lien on Proceeds 21
ARTICLE XII. COORDINATION OF BENEFITS 21

ARTICLE XII. INTERPRETATION AND DETERMINATIONS 23
ARTICLE XIV. CLAIMS PROCEDURES 23
14.1. Notice of Claim 23
14.2. Claims Review Procedure 24
14.3. Effect of Fiduciary Action 24
ARTICLE XV. ERISA RIGHTS 25
ARTICLE XVI. ERISA INFORMATION 26
ARTICLE XVII. MISCELLANEOUS 27
17.1. Incapacitation 27
17.2. No Admission of Liability 27
17.3. Limit on Liability 27
17.4. Plan Not a Contract of Employment 27
17.5. Plan Not Workers' Compensation Insurance.. 28
17.6. Non-Alienation 28
17.7. No Guarantee of Tax Consequences 28
17.8. Severability 28
17.9. Construction 28
17.10. Governing Law 28
CONCLUSION 29
APPENDIX A 1

INTRODUCTION TO THE OCCUPATIONAL BENEFITS PLAN FOR THE EMPLOYEES OF MEMORIAL HERMANN HEALTHCARE SYSTEM HOSPITAL

In introducing the Summary Plan Description of the Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare System (the "**Plan**"), we want to explain the reasons for adopting the Plan and the effects we anticipate it will have on you and your fellow employees.

Purpose: Memorial Hermann Healthcare System will care for its employees based on the guidelines of the plan, which it can control, instead of under the Texas Workers' Compensation Act, which appears to be beyond control. The Plan is designed to focus maximum attention and resources on creating and maintaining a safe and healthy working environment. Many Texas employers have adopted programs such as the Plan as a method for responding to work related injuries instead of relying on the Workers' Compensation system. Widespread abuses of the Workers' Compensation system, and the decline in prompt, fair and affordable service by Workers' Compensation insurance carriers, offer ample evidence that benefits due legitimately injured employees can be handled better within our organization than through insurance companies and outside providers.

Goals and Objectives: The Plan's goals and objectives include:

(a) Greater attention to loss prevention and loss reduction by every employee in our organization, thereby preventing injuries and reducing the severity of any injuries which do occur;

(b) More personalized attention to legitimate incidents involving on-the-job injuries, including prompt and caring attention by fellow employees;

(c) Providing medical and wage replacement benefits for our employees while avoiding the wasteful aspects of the Workers' Compensation system;

(d) Encouragement of prompt return to work by employees when they are released to return; and

(e) Identification of fraudulent and exaggerated claims and denial of benefits for those claims.

No Effect On Group Health Insurance Benefits: Because our group medical insurance benefits are designed to cover injuries and illnesses that are not job related, the adoption of the plan will **not** affect your group medical insurance benefits, if any. The adoption of the Plan will affect only the manner in which claims for on-the-job injuries will be evaluated and paid.

Certain Claims To Denied. The Plan is designed to compensate for legitimate on-the-job injuries, so not every claim will necessarily be approved for payment. The most obvious example is a fraudulent incident involving a claim for benefits when the incident either did not occur or was not work related. Such fraudulent claims should not be paid under Workers' Compensation either, but the internally administered Plan should increase the likelihood that fraudulent claims will be detected and not paid.

Effect of Adoption of the Plan on Employees. Employees should generally see very few effects from the adoption of the Plan. All on-the-job incidents will be reported in a similar manner and investigated thoroughly. Employees should notice increased attention to safety procedures to prevent injuries from occurring in the first

place. Certain cost-saving techniques should help to reduce the overall cost of the Plan, thereby allowing access to benefits for all covered employees. For example, medical treatment will be furnished by providers that have been chosen to provide our employees with quality care. A list of approved "preferred providers" will be maintained by the Personnel Department for your inspection and use. **Charges for treatment of work-related claims from physicians, hospitals, clinics and other health care providers that are not preferred providers will generally NOT be reimbursed; exceptions will be made for emergency situations.**

Your understanding and support of the Plan are essential to its success, so please read this Summary Plan Description carefully. We encourage and expect every member of our organization to give his or her full cooperation so that we can work together more productively and more safely. If you have any questions about our occupational benefits and safety program, please do not hesitate to contact your supervisor or the Personnel Department.

Thank you,

Memorial Hermann Healthcare System

FOREWORD

The Benefits provided under this Plan are for the exclusive benefit of the Eligible Employees of Memorial Hermann Healthcare System (the "Plan Sponsor") and any of its affiliates which adopt the Plan. These Benefits are intended to be continued indefinitely, however, the Plan Sponsor reserves the unilateral right to make any changes without notice to the Plan which it deems to be

necessary or appropriate to comply with applicable law, regulation or other authority issued by a governmental authority. The Plan Sponsor also reserves the unilateral right to amend, modify, suspend or terminate without notice all or any part of the Plan, modify or terminate the amount, type and length of payments permitted under the Plan, and to make any other changes without notice that, consistent with applicable law, it deems to be necessary or appropriate in its sole discretion. You should not, therefore, assume that the Benefits which are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right to amend, modify, suspend or terminate such Benefits. Furthermore, the Plan's Administrative Committee reserves the unilateral right to interpret, construe, construct and administer the terms and provisions of the Plan, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making any and all decisions concerning Benefits, including any factual determinations that may impact a claim for Benefits. Decisions made by the Administrative Committee will be final and binding on all interested persons subject only to the claims appeal procedures of the Plan.

ARTICLE I. OVERVIEW

The Plan is intended to provide each Eligible Employee with certain limited Benefits in the event that the Eligible Employee should sustain an Occupational Bodily Injury, Disease or Cumulative Trauma. Any Benefits payable pursuant to the Plan are exclusive as the Employer does not carry insurance under the Texas Workers' Compensation Act (except with respect to Life Flight

Employees) and the Employer's group medical plan, if any, for employees and their dependents does not provide coverage for Occupational Bodily Injury, Disease or Cumulative Trauma.

This Plan is an "employee welfare benefit plan" as defined in Section 3(1) of ERISA, and it is not maintained solely for the purpose of complying with applicable workers' compensation laws or disability insurance laws for purposes of Section 4(b)(3) of ERISA. Benefits available under the Plan include payments for medical care, disability income, dismemberment and death, as well as an employee safety training grogram and certain other benefits described in Section 3(1) of ERISA.

Benefits determinations are made on a case-by-case basis. In addition, an Eligible Employee may lose any right to receive Benefits under the Plan as provided below in Article IX entitled "EXCLUSIONS FROM COVERAGE."

ARTICLE II. DEFINITIONS

2.1. **Accident** means a sudden, unforeseen, unexpected, abrupt and specific event that occurs by chance or from unknown causes at a specifically identifiable time and place. In any event, the Accident must occur while the Eligible Employee is in Active Service in order for the Bodily Injury resulting therefrom to be eligible for coverage under the Plan.

2.2. **Active Service** means the Employee is performing on a work day the duties of his employment with the Employer, either at his customary place of employment or at a location required by his Employer for furthering its business interest. An Employee is not in Active Service if

he is confined in any institution providing care or treatment of physical or mental infirmities.

Active Service includes making a business trip as directed by the Employer; provided, however, Active Service does not include:

(a) Commuting or other transportation to and from the place of employment unless:

(i) the transportation is furnished as part of the contract of employment or is paid for by the Employer; or

(ii) the means of such transportation are under the control of the Employer; or

(iii) the Employee is directed in his employment to proceed from one place to another place; or

(b) Personal deviations by the Employee. "Personal deviation" means an activity that is not reasonably related to the Employer's business, and not incidental to the business trip. Active Service will start at the actual start of the business trip. It does not matter whether the trip starts at the Employee's home, place of work, or other place. The business trip in Active Service will end when the Employee:

(i) arrives at his home or place of work, whichever happens first; or

(ii) makes a personal deviation.

2.3. **Administrative Committee** means the committee of Employees selected by the Board to oversee the day-to-day administration of the Plan and to make Determinations, as more fully set forth in Article XV hereof.

2.4. **Administrator** means the Plan Sponsor as the Plan Administrator for purposes of ERISA. In certain contexts, the term "Administrator" may refer to a Third Party Administrator if one has been appointed and is serving under the Plan.

2.5. **Benefits** means the Compensation payments and any non-monetary benefits that are awarded, in the discretion of the Administrative Committee, to or on behalf of an Eligible Employee. Benefits also include the Employer's safety training program pursuant to which the Employer instructs Employees as to proper, on-the-job, safety procedures which are designed to reduce the potential for Accidents.

2.6. **Board** means the Board of Directors (or equivalent governing authority) of the Plan Sponsor.

2.7. **Bodily Injury** means:

(a) an identifiable physical injury to an Eligible Employee which is caused by an Occupational Accident that is promptly reported in accordance with the procedures established by the Employer for reporting Accidents, and

(b) solely and independently of any other cause, except illness or infection directly resulting from such injury, or medical or surgical treatment rendered necessary by such injury, occasions an Eligible Expense, Partial Disability, Total Disability, Dismemberment or Death of the Eligible Employee within twelve (12) months from the date of the Accident.

Bodily Injury does not include mental injury, emotional distress, mental trauma, or similar injury to mental or emotional state of an Employee.

2.8. **Cumulative Trauma** means damage to the physical structure of the body occurring as a result of repetitious,

physically traumatic activities that occur in the scope of Active Service. A physical activity will be considered a repetitious activity to the extent it is regularly performed by the Employee at least six (6) hours per working day.

2.9. **Death** means, as a basis for a claim receive Compensation, the death of an Eligible Employee directly resulting from a Bodily Injury and not as the result of prior, intervening or subsequent conditions, actions or events.

2.10. **Determination** means the decisions of the Administrative Committee concerning whether or not to award Benefits for a Bodily Injury, Disease or Cumulative Trauma, in what amount and for what duration.

2.11. **Disease** means an unhealthy condition of the body arising out of and in the course and scope of Active Service that (i) causes damage or harm to the physical structure of the body, (ii) has been caused by exposure to environmental or physical hazards in the scope of employment, (iii) is generally accepted by the National Center of the Diseases to be a disease, and (iv) is a condition not caused by an Accident. The term "Disease" does not include an ordinary disease of life to which the general public is exposed outside of Active Service.

2.12. **Dismemberment** means the loss of any one or more members resulting from Bodily Injury. "Member" means an eye, foot or hand. Loss with regard to eyes means irrecoverable loss of entire sight as certified by a Physician specializing in ophthalmology. Loss with regard to a foot or hand means the degree of functional loss is such that there is total effective loss of use. All decisions concerning the Dismemberment of an Eligible Employee shall be made by the Administrative Committee based on

the opinion of a Physician selected or pre-approved by the Administrative Committee.

2.13. **Eligible Employee** means an Employee who has satisfied the Plan's eligibility requirements pursuant to Article III of the Plan and whose participation in the Plan has not been terminated as provided herein.

2.14. **Eligible Expense** means, subject to the exclusions and limitations specified in the Plan, a charge or expense that results from a Bodily Injury, Disease or Cumulative Trauma for which the Administrative Committee, in its discretion, has made a Determination to award Compensation; provided that such charge or expense is:

(a) incurred by an Employee for Medically Necessary care, treatment or Rehabilitation of a covered Bodily Injury, Disease or Cumulative Trauma;

(b) prescribed by a Physician (except in the case of Emergency Medical Care which need not be prescribed by a Physician);

(c) not in excess of the Usual and Customary Charge;

(d) not an Excluded Medical Expense; and

(e) not experimental (as recognized in the United States) or provided mainly for the purpose of medical or other research.

Eligible Expenses include the following:

(a) Hospital charges for semi-private room and board;

(b) Charges for use of an operating or emergency room;

(c) Fees for Physicians and surgeons (including oral surgeons);

(d) Charges for prosthetic appliances including artificial limbs;

(e) Charges for emergency service transportation to a local Hospital;

(f) Charges for medical or surgical treatment, services, durable medical equipment, prescription drugs and any other service ordered by a Physician;

(g) Dental services for the treatment of injury to sound natural teeth;

(h) Services of a Home Health Care Agency; and

(i) Charges for physical Rehabilitation treatment.

2.15. **Emergency Medical Care** means those Medically Necessary health care treatments, services or supplies which are provided for the repair or treatment of a Bodily Injury, Disease or Cumulative Trauma which, if not immediately diagnosed and treated, could reasonably be expected to result in physical impairment or loss of life.

2.16. **Employee** means a person who is employed by an Employer as a common law employee or officer whose compensation is reported on an IRS form W-2 (or its successor) by the Employer, but such term shall not include independent contractors or subcontractors, any person employed by an independent contractor or subcontractor, or any person with a status other than that of

common law employee or officer of an Employer; provided, however, persons for whom the Employer is liable under a temporary service contract shall be considered Employees solely for the purpose of coverage hereunder. In accordance with Section 3.4, the term Employee may also refer to a former Employee who is receiving Benefits hereunder for a Bodily Injury, Disease or Cumulative Trauma that occurred while he was in Active Service.

2.17. **Employer** means, individual and collectively, Memorial Hermann Healthcare System, Memorial City Medical Center, and any other affiliated entity which adopts the Plan with the consent or ratification of the Board.

2.18. **ERISA** means the Employee Retirement Income Security Act of 1974, as amended, and the regulations and other authority issued thereunder by the appropriate governmental authority. Reference to any section of ERISA shall include references to any successor section of ERISA.

2.19. **Excluded Medical Expense** means any of the following:

(a) any charge or expense incurred while confined in a hospital owned or operated by the United States Government or an agency thereof for treatment of a military service-connected disability;

(b) any charge or expense that, absent the coverage provided by the Plan, the Employee would not be legally required to pay;

(c) any charge or expense that is covered under any worker's compensation, unemployment compensation, or disability benefits law or

any similar law of the United States or any State or political subdivision thereof;

(d) any charge or expense for the care and treatment of mental, nervous or emotional disorders, alcoholism or drug abuse;

(e) any charge or expense for treatment or service that may be rendered safely and reasonably by a person not medically skilled or that is designed to assist the patient with daily living activities unless such charge or expense is pre-approved by the Administrative Committee;

(f) any charge or expense for services or supplies of common household use, including but not limited to exercise equipment, air conditioners, air purifiers, water purifiers, allergenic mattresses and blood pressure kits, whether or not any such item is prescribed by any Physician unless such charge or expense is preapproved by the Administrative Committee;

(g) any charge or expense that is reimbursable by any local or other government agency;

(h) any charge or expense for room and board in excess of a semi-private room rate, unless the attending Physician deems such an arrangement to be Medically Necessary;

(i) any charge or expense for mileage to or from appointments or visits with Preferred Providers and Health Care Facilities; or

(j) any charge or expense in excess of the maximum Benefit limitations of the Plan, as set forth in Section 8.4.

The above list is not intended to limit the types of charges or expenses that may be classified as Excluded Medical Expenses by the Administrative Committee depending on particular circumstances.

2.20. **Health Care Facility** means a Hospital, Surgicenter, Skilled Nursing Facility or a Home Health Care Agency.

2.21. **Home Health Care Agency** means a public or private agency that has been prescribed by a Physician and specializes in giving nursing and other therapeutic services in the Eligible Employee's home, provided that the agency is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

2.22. **Hospital** means a legally constituted institution which:

(a) is primarily engaged in providing diagnostic, medical and surgical facilities for the care and treatment off injured or sick persons and is compensated for such treatment; and

(b) has a staff of one or more Physicians available at all times; and

(c) has twenty-four (24) hour-a-day nursing services by registered nurses (R.N.'s) or other nursing services under the complete responsibility of the Physician in charge; and

(d) maintains In-Patient facilities; and

(e) is licensed as a Hospital by the appropriate state agency; and

(f) is appropriately certified or approved in accordance with the standards prescribed by the Joint Commission on Accreditation of Healthcare Organization (JCAHO).

"Hospital" does not include any institution which primarily is a facility for the care and treatment of alcohol or drug abuse (including detoxification and rehabilitation).

2.23. **Incident Report** means a report prepared by management, in accordance with the Employer's occupational safety program, after an Accident or other incident has occurred which describes the time, place and general description of the incident that resulted in Bodily Injury or Disease to the Eligible Employee.

2.24. **Life Flight Employee** means any Employee who provides air ambulance services though the Life Flight operations in the Hermann Division and who is covered under the Texas Workers' Compensation Act.

2.25. **Medical Records** means all medical information relevant to the Bodily Injury, Disease or Cumulative Trauma of an Eligible Employee, including the diagnosis, prognosis and treatment of the Eligible Employee in narrative form and all reports and evidence of lab test results, x-rays, therapy, drugs, autopsy and other tests and procedures.

2.26. **Medically Necessary** means medical services, procedures or supplies which are:

(a) required, recognized and professionally accepted nationally by Physicians as the usual, customary and effective means of diagnosing or treating the condition;

(b) economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the medical condition; and

(c) not primarily for the convenience of the Employee, the Employee's family or the Employee's Physician or other provider of medical services, supplies or procedures.

Even if the service, supply or procedure is determined to be Medically Necessary, the Plan does not cover services, supplies, or procedures that are excluded by any condition, exclusion or other term or provision in the Plan.

For confinement in a Hospital, Medically Necessary also means that treatment of the Bodily Injury, Disease or Cumulative Trauma requires an overnight stay. Treatment that is educational, experimental, investigational or done primarily for research will not be considered as Medically Necessary.

2.27. **Occupational** means the Employee is performing in Active Service.

2.28. **Other Occupation** means any gainful occupation that the Employee is or becomes qualified for by education, training or experience.

2.29. **Partial Disability** means an Eligible Employee's partial inability (whether temporary or permanent) because of a Bodily Injury, Disease or Cumulative Trauma to (i) perform all essential acts and duties of his regular occupation and (ii) earn the equivalent wages that the Eligible Employee was receiving at the time of the Bodily Injury, Disease or Cumulative Trauma in his regular occupation, as determined by the Administrative Committee based on the opinion of a Physician selected or

pre-approved by the Administrative Committee. With respect to a Bodily Injury resulting in a Partial Disability, the Partial Disability must commence within thirty (30) days of the date of the Accident which caused the Bodily Injury.

2.30. **Physician** means a licensed medical practitioner who is (i) practicing within the scope of his license and (ii) licensed to prescribe and administer drugs or to perform surgery, as well as any other licensed medical practitioner whose services are required to be covered by law if he is operating within the scope of his license and performing a service for which Benefits may be awarded when performed by a Physician. For purposes of this Plan, a Physician cannot be the Employee, the Employee's spouse, or an ancestor, sibling, or descendant of the Employee or his spouse.

2.31. **Plan** means this "Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare System", as it may be amended from time to time. The Plan is an amendment and restatement of the Plan of the same name that was originally effective on October 1, 1992.

2.32. **Plan Administrator** means the Plan Sponsor acting through the Administrative Committee which shall be a named fiduciary hereunder for purposes of ERISA.

2.33. **Plan Sponsor** means Memorial Hermann Healthcare System.

2.34. **Plan Year** means the twelve-month period ending on June 30 of each year.

2.35. **Pre-existing Condition** means an injury, disease, cumulative trauma injury, sickness or other

medical condition for which, within two (2) years prior to (i) the Employee's effective date of initially becoming an Eligible Employee or recommencing participation in the Plan as an Eligible Employee or (ii) the date of occurrence of the Bodily injury, Disease or Cumulative Trauma, the Employee has (i) received medical care or took prescription drugs for such condition or (ii) experienced symptoms of sufficient significance, as determined by the Administrative Committee, to either (A) allow a Physician to diagnose the disorder or (B) cause a reasonably prudent person to seek diagnosis or treatment. The teem Pre-Existing Condition shall also include any condition related to the injury, disease, cumulative trauma injury, sickness or other medical condition described in the previous sentence. This section shall be construed in accordance with the requirements of the federal Family and Medical Leave Act of 1993, in situations when such Act is applicable.

2.36. **Preferred Provider** means those selected Physicians and other health care service providers who have agreed to follow administrative procedures established by the Plan Sponsor, Administrative Committee, or Third Party Administrator.

2.37. **Proof of Loss** means acceptable evidence (such as, an itemized bill or statement) required by the Plan to verify that the Eligible Employee has incurred a Bodily Injury, disease or Cumulative Trauma for which Benefits may be awarded under the Plan. The Proof of Loss must be promptly reported.

2.38. **Rehabilitation** means only those procedures which are performed for the purpose of restoring the function of motion, speech or vision lost as a result of Bodily Injury, Disease or Cumulative Trauma.

2.39. **Skilled Nursing Facility** means a section, ward or wing of a Hospital, or a freestanding healthcare facility, which:

(a) provides room and board;

(b) provides nursing care by or under the supervision of a nurse;

(c) provides physical, occupational and speech therapy furnished by the facility or by others under arrangements made by the facility;

(d) provides medical social services;

(e) provides drugs, biologicals, supplies, appliances and equipment ordinarily furnished for use in a skilled nursing facility;

(f) provides medical services by staff Physicians;

(g) has an agreement with a Hospital for diagnostic and therapeutic services, the transfer of patients and exchange of clinical records;

(h) provides other services necessary to the health and care of patients that are generally provided by skilled nursing facilities; and

(i) is licensed or registered in accordance with local and state laws and regulations.

2.40. **Third Party Administrator** means organization which, in the discretion of the Plan Sponsor, is engaged as contact claims administrator for the Plan. The Third Party Administrator, if any, shall be the named fiduciary for purposes of Section 402(a)(1) of ERISA with

respect to those discretionary duties undertaken by or assigned to it.

2.41. **Total Disability** means an Eligible Employee's complete inability (whether temporary or permanent) because of a Bodily Injury, Disease or Cumulative Trauma to (i) perform all essential acts and duties of his regular occupation and (ii) earn the equivalent wages that the Eligible Employee was receiving at the time of the Bodily Injury, Disease or Cumulative Trauma in his regular occupation, as determined by the Administrative Committee based on the opinion of a Physician selected or pre-approved by the Administrative Committee.

2.42. **Usual and Customary Charge** means any charge or expense that is:

(a) usual when it is the fee regularly charged (and which the patient is responsible to pay) in the absence of insurance or other third party reimbursement, by a Physician or other health care provider for a given treatment, service or supply; and

(b) customary in relation to what other Physicians and health care providers in the same geographic area charge for the same and similar treatment, service or supply.

"Same geographic area" means a geographically significant area as is necessary to establish a representative base of charges or expenses for the type of service or item at issue.

2.43. **Wage Continuance** means the Compensation attributable to lost or reduced earnings capacity which is payable to an Eligible Employee who has incurred a Partial Disability or Total Disability.

ARTICLE III. ELIGIBILITY

3.1. **Commencement.** An Employee who is in Active Service and whose primary and regular place of employment is located in the State of Texas shall be an Eligible Employee covered by the Plan as of the later of (i) October 1, 1992, or (ii) his first day of employment for the Employer.

3.2. **Cessation.** An Eligible Employee will cease to be an Eligible Employee covered under the Plan at the earlier of (i) the effective date and time on which the Plan is terminated, or (ii) the effective date and time on which the Employee's status as an Employee in Active Service is discontinued for whatever reason, including termination of employment, leave of absence or lay-off.

3.3. **Reinstatement.** An Eligible Employee covered under the Plan who is on a leave of absence, lay-off, termination or other severance from Active Service shall recommence his coverage under the Plan on the first day that he recommences employment in Active Service for the Employer.

3.4. **Continuation of Benefits.** Subject to the terms and provisions of the Plan, an Eligible Employee's right to receive Benefits awarded under the Plan for a Bodily Injury or Disease that occurred prior to his termination of employment with an Employer shall not be curtailed solely as the result of such termination provided that such Employee is otherwise eligible to receive Benefits as determined by the Administrative Committee.

3.5. **Eligibility Limited to Periods Of Active Service.** The purpose of the Plan is to provide coverage for Occupational Bodily Injury or Disease only; consequently,

coverage shall not extend to non-work days or to any other time period when an Employee is not in Active Service.

3.6. **Non-Discrimination.** Notwithstanding any contrary provision of the Plan, all Eligible Employees shall be treated under the Plan on a non-discriminatory basis without regard to their race, color, religion, national origin, ancestry, sex, disability, age or employment position with the Employer. The Administrative Committee shall make Determinations in accordance with this standard.

ARTICLE IV.
INCIDENT REPORTING AND INVESTIGATION

4.1. **Employee's Responsibilities.**

(a) **Employee Safety Training Program.** One of the specific Benefits provided under the Plan is the Employee safety training program maintained by the Employer, which program is designed to reduce the potential for Accidents, Diseases or Cumulative Traumas. Employees will receive on-the-job safety training and instruction from the Employer. Employees are required to work in a safe manner pursuant to instructions and to otherwise abide by the Employer's occupational safety rules and procedures as then in effect. The Employee safety training program is a part of the Plan.

(b) ***Reporting the Bodily Injury, Disease or Cumulative Trauma.*** An Employee must report an Accident or other incident that results or could result in Bodily Injury, no matter how slight, to his supervisor immediately. If his supervisor is not readily available, the Accident must be immediately reported to another supervisor. Unless the delay is due to medical necessity, any

Bodily Injury not reported within the job shift in which the Bodily Injury reportedly occurred shall not be considered timely reported, which may result in a Determination by the Administrative Committee to deny Benefits to the Employee. Prompt and accurate reporting of incidents is essential to a fair assessment of entitlement to, and the amount of, Benefits which the Employee may be eligible to receive. In no event will a report of a Bodily Injury be even considered if it is not reported within thirty (30) days from the date of alleged occurrence of the Accident.

Unless there is a valid and compelling reason for the delay as determined by the Administrative Committee, Employee must report a Disease or Cumulative Trauma to his supervisor during the period of his employment as an Employee and seek prompt medical attention as soon as reasonably possible after he notices symptoms of the Disease or Cumulative Trauma.

(c) **Incident Report.** The Employee must assist the Employer in completing an Incident Report which details all relevant information concerning the Bodily Injury, Disease or Cumulative Trauma incurred. With respect to an Accident or other incident causing a Bodily Injury, the Employee must provide an account of the incident, including how it occurred, who was involved, the Bodily Injury sustained and which parts of the body were hurt. The Employee may be requested by the Employer to provide his account of the incident in writing. With respect to a Disease or Cumulative Trauma, the Employee must provide an account of all details deemed relevant by the Employer.

(d) **Additional Reports.** The Administrative Committee may require the Employee to submit proof of

continued Partial Disability or Total Disability on a periodic basis, as often as it considers necessary and reasonable. The Administrative Committee may discontinue Benefits until the Employee provides such proof.

(e) **Treatment.** The Employee must seek immediate medical care as directed by the Employer. The Employee must seek care from a Preferred Provider (with exceptions as provided in Article VII). The Employee must report back to the Employer when released by his Physician. The Employee must keep all appointments with the Physician and follow the Physician's instructions regarding treatment, recovery, and return to work.

4.2. **Employer's Responsibilities.**

(a) **Medical Treatment.** As dictated by the nature or severity of the Bodily Injury, Disease or Cumulative Trauma, the Employee should be instructed to seek prompt first aid or Emergency Medical Care and the Employer should provide necessary assistance to the Employee.

(b) **Incident Report.** Upon receiving notice of a Bodily Injury, the Employer will make such investigation and take such actions as may be deemed appropriate under the circumstances.

ARTICLE V. DRUG AND ALCOHOL TESTING

An Eligible Employee must submit when requested to drug and alcohol testing done at the time of the Bodily Injury by a person designated by the Employer who has been trained to administer such tests, or by a Physician (or other healthcare service provider) at the time of initial medical treatment for a Bodily Injury, Disease or Cumulative Trauma and at any other time that the Administrative

Committee deems appropriate while the Employee is receiving Benefits under the Plan. If the Administrative Committee determines that an Employee was under the influence of drugs (other than prescription drugs used as prescribed) or alcohol at the time of a Bodily Injury, Disease or Cumulative Trauma, if the Employee refuses to take any such drug or alcohol test, tests positive for drug or alcohol use, or tampers with such test, the Employee will be ineligible to receive any further Benefits on account of that Bodily Injury, Disease or Cumulative Trauma. For more detail on drug and alcohol testing, reference should be made to exclusion number 9 in Article IX hereof.

ARTICLE VI RELEASES

As a condition of the Plan, as it was designed and adopted by the Plan Sponsor in such capacity, the Plan Administrator reserves the right to require any Employee who incurs a Bodily Injury, Disease or Cumulative Trauma, or any other potential claimant, to execute and deliver to the Plan Administrator, on a form provided by the Plan Administrator, a full release of liability and covenant not to sue (except with respect to Benefits claims under the Plan), before Benefits are awarded under the Plan or at any other time in consideration for the award of any Benefits. In the event of Employee's Death, the Plan Administrator may require a full release of liability and covenant not to sue from, without limitation, members of the Employee's family or any other potential claimants. The full release of liability and covenant not to sue referred to in this paragraph shall not include claims for Benefits under the Plan.

In addition, the Plan Administrator reserves the right to require any Employee who incurs a Bodily Injury, Disease or Cumulative Trauma to execute and deliver to the Plan Administrator (and/or to the Third Party Administrator, if any, or other designee of the Plan Administrator) a full release of such Employee's Medical Records pertaining to the Bodily Injury, Disease or Cumulative Trauma (on forms provided by the Plan Administrator and/or its designee) prior to any Determination with respect to the Employee's claim for Benefits.

ARTICLE VII.
APPROVED MEDICAL PROVIDERS

The Plan Sponsor has designated the Health Care Facilities and Preferred Providers that an Eligible Employee must utilize in order for Benefits to be awarded under the Plan. Subject to medical specialty limitations and the specific type of treatment required, Employees shall generally select their own Physicians from the list of Preferred Providers.

The Administrative Committee, in its discretion, may nevertheless award Benefits for Usual and Customary Charges from Health Care Facilities, Physicians or other health care service providers that are not Preferred Providers, or otherwise previously approved by the Plan Sponsor, in the event that (i) a Bodily Injury occurs outside of the Employer's geographic area, (ii) Emergency Medical Care is required, or (iii) specialized medical treatment is required and pre-approved for payment by the Administrative Committee. After Emergency Medical Care is rendered, an Employee shall be transferred to a

Preferred Provider as soon as such transfer is practical based on the Employee's condition.

The Employer (and its agents and delegates, including the Administrative Committee) shall not have any responsibility for the actual medical or other health care services provided by the Employee's attending Physician and other health care providers. Physicians and other health care service providers are not agents of the Employer, and the Employer shall not be liable or responsible for the acts or omissions of any health care service provider. The Plan is not intended to affect the patient-provider relationship. The actual medical treatment of a Bodily Injury, Disease or Cumulative Trauma remains the prerogative and responsibility of the attending Physician and other health care providers based on their independent medical judgment for the provision of quality health care.

The Administrative Committee is fully authorized by the Plan Sponsor to monitor the treatment of any Employee who is receiving Benefits hereunder, and to utilize such other case management and cost containment procedures as it deems to be appropriate, in its discretion, based on particular circumstances.

ARTICLE VIII. BENEFIT AWARDS

8.1. **Administrative Committee Review**. The Administrative Committee shall evaluate and review a claim for Benefits to determine whether an award of Benefits is warranted under the terms and provisions of the Plan. Each claim shall be evaluated on a case-by-case basis. In making Determinations, the Administrative Committee shall consider all relevant information, including but not limited to, Incident Reports and Medical

Records, concerning (i) the incident, (ii) the nature and severity of the Bodily Injury or Disease sustained, (iii) time expected to be lost from work, (iv) the treatment, diagnosis and prognosis as prescribed by the attending Physician, and (v) the terms and conditions of the Plan.

Determinations that are made by the Administrative Committee shall be made by the majority vote of its members. Each Administrative Committee member shall have one vote. In making Determinations, the Administrative Committee members shall take into account the applicable terms and provisions of the Plan.

There shall be no interrrelationship between the Plan and the Employer's then-existing non-Occupational group medical plan, if any, for eligible Employees and their eligible dependents as described in such plan. For example, Occupational-related claims which are accepted under the Plan, in whole or in part, cannot be submitted for reimbursement under such group medical plan or vice-versa.

Determinations of the Administrative Committee shall be made on a non-discriminatory basis with respect to the Eligible Employees. The Secretary of the Administrative Committee or his delegate shall maintain adequate records and copies of all relevant information used in evaluating a claim and making a Determination.

The Administrative Committee may delegate responsibility for review and evaluation of claims for Benefits to one or more named individuals who may or may not be members of the Administrative Committee. The Administrative Committee has delegated such authority to the Occupational Health and Safety Manager. However, any Eligible Employee whose claim is denied or partially

denied by such individual can appeal such denial to the Administrative Committee by giving written notice of such appeal to the Administrative Committee. In the event that the Administrative Committee or its authorized delegate denies any claim and thereafter, the Administrative Committee or its authorized delegate determines that such claim should be allowed, any allowable medical reimbursement benefits shall first be paid to the Employer's group medical plan to the extent that covered benefits have been paid to the Employee pursuant to such plan.

8.2. **Death or Dismemberment; Schedule of Benefits.** In the event of Bodily Injury resulting in the Death or Dismemberment of an Eligible Employee, any Benefits payable to or on behalf of the Eligible Employee shall be determined by reference to a separate schedule of Benefits, attached hereto as Appendix A and incorporated herein by reference. The schedule of Benefits in Appendix A may be increased, decreased or otherwise amended as determined by the Administrative Committee from time to time.

In the event of the Death of an Eligible Employee, any Death Benefits payable hereunder shall be paid to the personal representative of the estate of the deceased Eligible Employee after the Administrative Committee receives appropriate directions. In the event that no administration is had on the Eligible Employee's estate, any Death Benefits payable hereunder shall be paid to the Eligible Employee's heirs at law, as such heirs are determined by the Administrative Committee in its discretion. Each recipient of a Death Benefit may be required to sign an appropriate release of claims under the Plan as determined by the Administrative Committee. Payment of any Death Benefits hereunder to the person or persons directed

by the Administrative Committee shall be in complete discharge and satisfaction of any obligation or liability hereunder to the extent of such payment.

8.3. **Wage Continuance.** Except as specifically provided in the immediately succeeding paragraph which pertains solely to Life Flight Employees, each Eligible Employee who incurs a Partial Disability or Total Disability resulting in lost time from Active Service shall be eligible to receive Wage Continuance in an amount, determined for each Plan Year by the Administrative Committee in its sole discretion, not to exceed not to exceed the lesser of (i) 130 percent of the maximum weekly payment payable under the Texas Workers' Compensation Act, or (ii) eighty-five percent (85%) of the Employee's gross salary or hourly wages per pay period.

Notwithstanding the provisions of the immediately preceding paragraph, each Life Flight Employee who incurs a Partial Disability or Total Disability resulting in lost time from Active Service shall be eligible to receive Wage Continuance in an amount equal to the difference, if any, of such Employee's gross salary or hourly wages over the amount of wage continuation benefits the Life Flight Employee is entitled to receive under the Texas Workers' Compensation Act.

For purposes of determining an Eligible Employee's gross salary or wages, the Administrative Committee shall base its computation on the Employee's actual hours worked per pay period over the seven (7) consecutive pay periods immediately preceding the first day of lost-time due to the Partial Disability or Total Disability; provided, however, if the Employee has not been in Active Service for at least seven pay periods at such time, the Administrative

Committee shall determine the amount of Wage Continuance based on his average wages for the period in which he has been in Active Service.

The Administrative Committee shall make a Determination concerning whether the Employee (i) is entitled to Wage Continuance, (ii) the amount and frequency of any payments of Wage Continuance, and (iii) the length of time that the Wage Continuance shall be paid. The Administrative Committee will also require the Employee to periodically report his health status to the Administrative Committee and when he expects to return to work during any period when the Employee is on an approved medical or disability leave.

The Plan shall not provide duplicate payments to or on behalf of any Employee. In that regard, to the extent not prohibited by applicable law, Wage Continuance otherwise payable to an Eligible Employee will be reduced by the Administrative Committee dollar-for-dollar by the amount of any (i) absent-time pay paid from the regular payroll of an Employer; (ii) salary continuation paid from the regular payroll of an Employer; (iii) salary or wages paid to an Eligible Employee who has a Partial Disability for services rendered in a light-duty or other modified or restricted capacity; (iv) benefits payable under the Social Security Act, workers' compensation, unemployment compensation law, occupational disease law, or another law; and (v) benefits payable under any short-term or long-term disability insurance policy or other employee benefit program maintained by the Employer which covers the Employee. An Eligible Employee is required to take whatever benefits are available to him from other sources besides the Plan, including enrolling under the Social

Security Act to receive benefits for a disability that is covered under said Act.

Wage Continuance for lost time from Active Service shall commence on the sixth (6th) regularly scheduled work day immediately following the first day of the excused absence from Active Service. Subject to the terms, limitations and conditions of the Plan, an Employee shall be eligible to continue to receive Wage Continuance hereunder as long as, pursuant to the current directive of the treating Physician, such Employee remains unable to return to Active Service (in a full, light or modified duty capacity) due to a covered Bodily Injury, Disease or Cumulative Trauma. At the end of a 52-week period during which the Employee has continuously received Wage Continuance, the Administrative Committee shall review the Employee's situation to make a Determination regarding whether (i) to authorize further payments of Wage Continuance for such additional period as the Employee is unable to return to Active Service or for such other continuation period as is determined by the Administrative Committee to be appropriate or (ii) to commute all future claims hereunder by providing the Employee with a final lump-sum payment or periodic structured payments, as determined by the Administrative Committee, in consideration for the Employee's execution of a release of liability form whereby he agrees to release any and all claims to further Compensation under the Plan and from the Employer directly.

In the event that the Employee is authorized by his treating Physician to return to Active Service in a light or modified duty capacity, his Wage Continuance hereunder shall be reduced by the amount of wages that he earns in such light or modified duty capacity.

After a Physician selected or pre-approved by the Administrative Committee issues a medical release permitting the Employee to return to full, light or modified duties, the Administrative Committee will direct the Employee to return to work and perform duties, light or otherwise, if any are assigned by the Employer. The Employee will return to work duties assigned by the Employer when directed to do so by the Administrative Committee. Any Employee who fails or refuses to return to work when so directed by the Administrative Committee shall be subject (i) to immediate cessation of his Wage Continuance and other Benefits under the Plan, as determined by the Administrative Committee, and/or (ii) termination of employment as determined by the Employer in its discretion without regard to the Plan.

The provisions of this Section shall be construed in accordance with the requirements of the Americans with Disabilities Act of 1990, as amended, to the extent applicable.

8.4. **Maximum Benefits**

(a) ***Bodily Injuries.*** The maximum amount of Benefits provided to, or on behalf of, an Eligible Employee under the Plan for Bodily Injury, including without limitation Bodily Injury resulting in Death, Dismemberment, Partial Disability or Total Disability, shall not exceed an aggregate lifetime limit of Two Million Dollars ($2,000,000) per Eligible Employee, without regard to the number of Bodily Injuries. Nothing contained in the Plan requires, or should be construed to require, the Administrative Committee to award the maximum amount or any amount of Benefits hereunder.

(b) ***Diseases.*** The maximum amount of Benefits provided to or on behalf of an Eligible Employee under the Plan for Disease shall not exceed an aggregate lifetime limit of One Million Dollars ($1,000,000) per Eligible Employee, without regard to the number of Diseases. Nothing contained in the Plan requires, or should be construed to require, the Administrative Committee to award the maximum amount or any amount of Benefits hereunder.

(c) ***Cumulative Traumas.*** The maximum amount of Benefits provided to or on behalf of an Eligible Employee under the Plan for Cumulative Traumas shall not exceed an aggregate lifetime limit of One Million Dollars ($1,000,000) per Eligible Employee, without regard to the number of Cumulative Traumas. Nothing contained in the Plan requites, or should be construed to require, the Administrative Committee to award the maximum amount or any amount of Benefits hereunder.

ARTICLE IX. EXCLUSIONS FROM COVERAGE

As determined by the Administrative Committee, an Eligible Employee shall be subject to (i) loss of any and all eligibility to receive, or to continue to receive, Benefits under the Plan or (ii) a reduction of Benefits, for any otherwise Eligible Expense caused by or resulting from any of the following events or reasons:

Employee Events:

1. The Employee fails to timely report the Accident or other incident causing the Bodily Injury or to report the Disease or Cumulative Trauma.

2. The Employee fails to fully cooperate in the investigation of the Accident or other incident or Disease or Cumulative Trauma.

3. The Employee fails or refuses to appear upon reasonable notice for an examination by an approved medical provider.

4. The Bodily Injury, Disease or Cumulative Trauma was caused in whole or in part by the Employee's violation of the Employer's employee safety practices and procedures as then in effect.

5. The injury or death was intentionally self-inflicted or aggravated while the Employee was sane or insane, or caused by his willful action, such as fighting or horseplay, in violation of the Employer's practices or procedures for on-the-job conduct.

6. The Employee fails to submit, as and when requested by the Employer or its agent, to a blood test, urinalysis, or other test designed to detect the presence of drugs or alcohol in the Employee's system.

7. The Bodily Injury was directly or indirectly caused by or resulted from a felonious assault or another act by a third person intended to injure the Employee because of personal reasons, and not directed at the Employee in the course and scope of his employment with an Employer.

8. The Bodily Injury was incurred as a result of voluntary participation by the Employee in an off-duty recreational, social, or athletic activity not part of work-related duties, except where these activities are required by employment with an Employer.

9. The Bodily Injury occurred at a time while the Employee:

(a) was impaired by or under the influence of alcohol. For the purposes of this subsection, the facts and circumstances of the Bodily Injury, the testimony of any witnesses, admissions or statements of the Employee, and any tests may be used to determine if the Employee was impaired by or under the influence of alcohol; or

(b) had an Alcohol Concentration of 0.05 or more. For the purposes of this subsection, "Alcohol Concentration" means the number of grams of alcohol per 100 milliliters of blood; the number of grams of alcohol per 210 liters of breath; or the number of grams of alcohol per 67 milliliters of urine; or

(c) was impaired by or under the influence of any Controlled Substance. For the purposes of this subsection, "Controlled Substance" means a drug or substance listed in applicable state laws and/or the Federal Controlled Substances Act and includes, but is not limited to, marijuana, hashish, heroin, cocaine, phencyclidine (PCP), benzodiazepines, narcotics, opiates, hallucinogens, inhalants and any other substances which have either a stimulant or depressant effect on the central nervous system, such as amphetamines or barbiturates. For the purposes of this subsection, detectable levels of any Controlled Substance use establishes a presumption that the Employee was impaired or under the influence; or

(d) was impaired by or under the influence of any Illegal Drug. For the purposes of this subsection, "Illegal Drug" means any drug which (i) is not legally obtainable, (ii) is legally obtainable but has not been legally obtained, or (iii) has been legally obtained but is not being used for prescribed purposes or in a prescribed manner. For the purposes of this subsection, detectable levels of any Illegal Drug use establishes a

presumption that the Employee was impaired or under the influence; or

(e) was impaired by or under the influence of any prescription drug which is not being used for the prescribed purposes or not taken in the prescribed manner.

10. The Bodily Injury occurred at a time when the Employee was engaged in, or as a result of his participation in, the commission or attempted commission of a crime, illegal occupation, felonious act or aggravated assault, or participation in a riot, rebellion or insurrection, or any act incident to any of these events (as used in this exclusion, "participation" means to take an active part in common with others and "riot" means any use of or threat to use force or violence by three or more persons without the authority of the law).

11. The Employee fails or refuses to follow the advice or course of treatment prescribed by health care providers approved under the Plan, including but not limited to, failing to return to Active Service after being cleared to return by a Physician.

12. The Employee is determined to have engaged in fraudulent or other deliberate conduct intended to mislead the medical provider or Employer as to the nature or severity of the claimed Bodily Injury, Disease or Cumulative Trauma.

13. The Employee seeks reimbursement for charges from a health care provider which is not a Preferred Provider, except as provided in Article VII hereof.

14. The incident causing the injury, disease or death is determined to be non-Occupational, i.e., to have occurred at a time when the Employee was not in Active Service including, without limitation, a non-occupational

injury that is merely aggravated at a time when the Employee is in Active Service.

15. The injury occurred as the result of an incident that cannot be identified as directly resulting from an Occupational Accident, including but not limited to, heart attack, stroke, seizure or allergies.

16. The failure or refusal of the Employee to sign a release of liability or a medical records release in accordance with Article VI.

Special Conditions or Events:

17. Any Pre-Existing Condition of the Employee that contributes to the Bodily Injury, Disease or Cumulative Trauma.

18. Mental and nervous conditions arising incident to the Bodily Injury, Disease or Cumulative Trauma, including for illustration and not limitation, (i) pain and suffering or mental anguish, (ii) loss of consortium, (iii) loss or damage of an emotional, psychological or psychiatric nature, and (iv) repetitious mental trauma.

19. War or an act of war whether declared or undeclared, acts of foreign enemies, hostilities (whether or not war is declared), civil war, insurrection, military or usurped power.

20. Participation in the military, naval or air forces of any country at war, declared or undeclared.

21. Ptomaine or bacterial infection other than bacterial infection occurring as a consequence of a cut or wound resulting from an Accident.

22. Radioactive contamination, except if caused by nuclear or radiological medicine used for patient care and diagnosis which is approved by state or

federal regulatory agencies and which is not for research purposes.

23. The Employee's claim is covered under the Jones Act, Federal Employers Liability Act or another federal, state or local law.

ARTICLE X. COMMENCEMENT OF BENEFITS

The Employer may provide Benefits hereunder to cover initial medical treatment at the time of the Bodily Injury, Disease or Cumulative Trauma, including Emergency Medical Care. Any further Benefits shall be awarded only after the Administrative Committee has made a Determination that additional Benefits are warranted under the Plan and any required releases have been secured. The provision of initial medical treatment does not mean that additional Benefits will be awarded hereunder. The Administrative Committee retains all rights to discontinue or reduce Benefits provided on behalf of an Employee if the Administrative Committee determines that there is a reason for such action under the Plan.

ARTICLE XI. SUBROGATION

11.1. **Plan's Right of Subrogation.** In the event of any Benefit payments made under the Plan to or on behalf of any Employee, the Plan shall, to the extent of such payments, be subrogated to all the rights of recovery and other rights of the Employee arising out of any claim or cause of action which may accrue because of the alleged accidental, negligent, intentional, or tortious conduct, act or omission of another person or entity including, without limitation, the Employer or another Employee (hereinafter

all such persons or entities shall be collectively referred to in this Article as a "third party"). Employee, by participation in the Plan agrees that his estate, and the legal representative of his estate, shall likewise be obligated and that the Plan shall be fully subrogated to any recovery or right of recovery that the estate may have against any third party on account of, or arising out of, the Employee's Bodily Injury, Disease or Cumulative Trauma, including without limitation, any wrongful death claim or action.

The Employee, or the legal representative or beneficiaries of Employee or his estate, shall notify the Plan Administrator of any claim or lawsuit against a third party or insurance carrier within thirty (30) days of the date that the claim is made or the lawsuit is filed. The Plan Administrator, on behalf of the Plan, also has the right to pursue any action to enforce its subrogation rights against a third party. The Plan Administrator may, in its discretion, elect not to enforce the Plan's subrogation rights to the extent consistent with its fiduciary obligations to the Plan.

11.2 **Employee's Agreement To Subrogation.** Employee, on behalf of himself and each beneficiary of a payment made on Employee's behalf, by accepting Benefits under the Plan, consents and agrees (i) that the Plan shall be promptly reimbursed for any payments made to or on the Employee's behalf under the Plan out of any monies recovered as the result of any lawsuit, judgment, order, award, settlement compromise, arbitration or other arrangement, and (ii) to include all Benefit paid or payable under the Plan in any liability or other claim against a third party. Furthermore, Employee and said beneficiaries promise and agree to take such action, to furnish such information and assistance, to execute and deliver any

assignments, reimbursement agreements and other instruments as the Plan Administrator may require to facilitate enforcement of the Plan's subrogation rights, and not to prejudice, or in any way detrimentally affect, such rights. The Plan's subrogation rights shall not be affected by any release, including a partial release, that is entered into without the consent of the Plan Administrator. The Plan's subrogation rights shall extend to (a) all conceivable sources of recovery, other than the Plan itself, including, by way of example and not limitation, any and all automobile insurance coverage (including uninsured/underinsured motorist coverage), no-fault coverage, medical insurance coverage, school insurance coverage, disability coverage and personal injury awards or settlements, and (b) all types of payments made by or on behalf of a third party, regardless of how designated, including, without limitation, payments for medical expenses, disability, accidental death or dismemberment, past or future wages or loss of earning capacity, pain and suffering, mental anguish, loss or consortium or companionship, and exemplary damages of any kind. For purposes of clarity and not limitation, to the extent that a recovery from a third party is obtained by an attorney for the Participant, the full amount that the Plan is entitled to recover hereunder shall not be offset or otherwise reduced by any attorney's fees or other costs of recovery that were not specifically approved in advance in writing by the Plan Administrator.

11.3 **Limitation To Plan's Subrogation Rights.** The Plan's subrogation rights (a) shall extend only to the recovery by the Plan of (i) the Benefits that it has paid or will pay to or on behalf of the Employee and (ii) the cost of prosecuting the claim including attorney's fees and court and collection costs and (b) shall fully apply even if the

Participant or beneficiary thereof has only received a partial recovery from a third party. Upon the advice of legal counsel, the Plan Administrator shall create a trust in connection with the Plan to hold any monies recovered, pursuant to the provisions of this Article, which constitute "plan assets" under ERISA.

11.4. **Subrogation Rights Not Affected By Payment.** The Plan's subrogation rights shall not be affected if Benefits are paid before the Plan Administrator obtains any additional agreement from the Employee (or from any other payee) or if the Plan Administrator does not request any such agreement. In addition, the failure or refusal of an Employee (or other payee) to sign an agreement at the request of the Plan Administrator recognizing the Plan's subrogation rights shall result in a forfeiture of all Benefits payable to that Employee (or other payee) even if such Benefits have already been paid, and the Plan Administrator shall retain a right to recover paid Benefits which are forfeited in such a manner; moreover, any such failure or refusal shall not affect the enforceability of the Plan's subrogation rights.

11.5. **Lien on Proceeds.** The Plan Administrator, on behalf of the Plan, shall have a lien against the proceeds of any settlement, award or judgment that results from a claim or lawsuit by or on behalf of an Employee who received Benefits under the Plan. Notice of the lien is sufficient to establish the Plan's lien against the third party or insurance carrier. The Plan Administrator shall be entitled to (i) deduct the amount of the lien from any future claims payable to or on behalf of the Employee if (A) the lien is not repaid or otherwise recovered by the Plan Administrator or (B) the Employee or other claimant fails to promptly notify the Plan Administrator of a payment

received from a third party or insurance carrier that is subject to the Plan's subrogation rights, and (ii) to otherwise take any action that the Plan Administrator deems necessary or appropriate to enforce the Plan's subrogation rights.

ARTICLE XII. COORDINATION OF BENEFITS

This Plan is not intended to provide any duplicate payments to or on behalf of any Employee. In order to prevent duplicate payments which exceed 100% of the Eligible Expenses or other allowable Benefits, this Article establishes a priority for payments from the Plan and from other sources. If any Eligible Employee (or his estate or beneficiaries) is entitled to payment from one or more Primary Plans (described below) as a result of a Bodily Injury, Disease or Cumulative Trauma, the Benefits payable shall be reduced (from the amount otherwise payable hereunder) by the total of all such payments from Primary Plans, if any, but cannot be reduced to less than zero. For purposes of this Article, a source of payment shall be considered a Primary Plan if it meets one of the following tests: (i) if that source does not have a coordination of benefits provision, it is a Primary Plan, or (ii) if that source does have a coordination of benefits provision and has covered the Employee as a person other than a dependent for a longer cumulative period than the Employee has been covered under the Plan, it is a Primary Plan.

When used in this Article, the term "Primary Plan" includes any policy, contact, plan or other arrangement

providing benefits or services for or by reason of medical or accident care or treatment, which benefits or services are provided by:

(1) group, blanket, or franchise insurance;

(2) any arrangement or coverage for individuals in a group whether on an insured or uninsured basis, including without limitation, Blue Cross and Blue Shield group plans;

(3) any coverage under governmental programs, and any coverage required or provided by any statute, except benefits paid under the Medical Assistance Act;

(4) any group or individual automobile insurance policy;

(5) any Health Maintenance Organization coverage on a group basis; or

(6) Part A or Part B of Title XVIII of the Social Security Act, as amended ("Medicare") as long as the Eligible Employee is eligible to enroll under Medicare and, to the full extent permitted by Medicare or other applicable law, regardless of whether the Employee has actually applied for Medicare coverage.

Any reduction in Benefits under this Article shall be based only on the total of other payments or other benefits to which an Eligible Employee is actually entitled under all Primary Plans. Any coordination of benefits provisions in Primary Plans shall be taken into consideration in computing any reduction of Benefits under this Article. If there are no Primary Plans providing payment for a given Bodily Injury, Disease or Cumulative Trauma, there shall

be no reduction of Benefits under the Plan pursuant to this Article.

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary payer regardless of the individual's election under PIP (personal injury protection) coverage with the vehicle insurance carrier.

If the Primary Plan is determined to be Medicare, a military program (CHAMPUS) or any other federal program, then any valid and enforceable coordination of benefits rules that are prescribed under applicable federal law or regulation that apply to such federal program will be followed hereunder.

In order to carry out the provisions of this Article, the Employer may obtain or release any relevant information to or from (i) any insurance carrier or plan administrator, (ii) any person making a claim under this Plan, or (iii) any other person or entity, all without the consent of or notice to the Employee or any other person or entity.

If payments for claims made hereunder are more than the amount payable under the Plan, the Plan Sponsor may recover the overpayment. The Plan Sponsor may seek recovery from one or more of: (i) any Employee to or for whom Benefits were paid; (ii) any insurance carrier; (iii) any Health Care Facility, Physician or other provider of care or services; or (iv) any other person or entity. The Plan Sponsor shall be entitled to deduct the amount of any such overpayments from any future claims payable to or on behalf of the Employee.

When any Benefits which would have been provided under the Plan have been provided under another plan or arrangement, the Plan has the right to pay the other plan the amount that the Administrative Committee determines will satisfy the intent of this Section. Any such payment made will be considered the payment of Benefits under the Plan and will satisfy any obligation to pay benefits under the Plan to the extent of such payments.

ARTICLE XIII.
INTERPRETATION AND DETERMINATIONS

The Administrative Committee reserves the absolute and unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including, without limitation, correcting any error or defect, supplying any omission, and reconciling any inconsistency. The Administrative Committee also reserves the absolute and unilateral right and power to make all decisions that may impact eligibility or a claim for Benefits, including findings of fact. Subject to the claims review procedure in Section 14.2, any Determination, decision, computation, or interpretation made by the Administrative Committee under the Plan shall be final, binding and conclusive on all persons and entities.

ARTICLE XIV. CLAIMS PROCEDURES

14.1. **Notice of Claim.** In the event that an Eligible Employee, Dependent, beneficiary or other person or entity (collectively referred to as the "Claimant") has a claim for any Benefit provided under the Plan, the Claimant must file a claim with the Administrative Committee on a form provided for such purpose. If the Claimant fails

to file a claim for Benefits, the Administrative Committee may take whatever steps are necessary to dispose of the Claimant's potential Benefits under the Plan, and shall be held harmless by Claimant and all other persons and entities in the performance of same.

Prior to authorizing any Benefits hereunder, the Administrative Committee or its designees may require the Claimant to provide Proof of Loss and other requested information, and to complete any releases, documents or forms which it deems to be necessary or appropriate for the proper administration of the Plan, including filing of all claims and requests for payment from any other source. In accordance with the applicable provisions of the Plan, the Administrative Committee shall make the Determination as to the right of any Claimant to any Benefit under the Plan.

14.2. **Claims Review Procedure.** If any claim for Benefits filed by a Claimant is wholly or partially denied, the Administrative Committee, or its designees will notify the Claimant of its decision in waiting. Such notification will be written in a manner calculated to be understood by the Claimant, and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary for the Claimant to perfect such claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if the Claimant wishes to submit a request for review. Such notification will be given within sixty (60) days after the claim is received by the Administrative Committee (or within one-hundred twenty (120) days if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to the

Claimant within the initial sixty (60) day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and the Claimant may then request a review of the claim in a written request directed to the Administrative Committee.

Within sixty (60) days after the date on which a Claimant receives a written notice of a denied claim (or, if applicable, within sixty (60) days after the date on which such denial is considered to have occurred) the Claimant (or his duly authorized representative) may (i) file a written request (including pertinent documents) with the Administrative Committee for a review of the denied claim, and (ii) submit written issues and comments to the Administrative Committee. The Administrative Committee or its designee will review the claim and notify the Claimant of its decision in writing. Such notification will be written in a manner calculated to be understood by the Claimant and will contain specific reasons for the decision, as well as specific references to pertinent Plan provisions. The decision on review will be made within sixty (60) days after the request for review is received by the Administrative Committee, or within one-hundred twenty (120) days if special circumstances require an extension of time for processing the request, such as a decision by the Administrative Committee to hold a hearing, provided that written notice of such extension and circumstances is given to the Claimant within the initial sixty (60) day period. If the decision on review is not made within such period, the claim will be considered denied as of the last day of such period. All final Determinations concerning claims made pursuant to this claims review procedure shall not be subject to further review by anyone, but shall be final,

conclusive and binding on the Claimant and all other persons and entities.

14.3. **Effect of Fiduciary Action.**

(a) The Plan shall be interpreted by the Administrative Committee in accordance with the terms of the Plan and their intended meanings. However, the Administrative Committee shall have the discretion to make any findings of fact needed in the administration of the Plan, and shall have the discretion to interpret or construe ambiguous, unclear or implied (but omitted) terms in any fashion it deems to be appropriate in its sole judgment. The validity of any such finding of fact, interpretation, construction or decision shall not be given de novo review if challenged in court, by arbitration or in any other forum, and shall be upheld unless clearly arbitrary or capricious.

(b) To the extent the Administrative Committee or another Plan fiduciary has been granted discretionary authority under the Plan, the prior exercise of such authority by the Administrative Committee or other Plan fiduciary shall not obligate it to exercise its authority in a like fashion thereafter.

(c) If, due to errors in drafting any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Administrative Committee in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Administrative Committee in a fashion consistent with its intent, as determined by the Administrative Committee. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

(d) This Section may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretation by the Administrative Committee or by any other Plan fiduciaries. All actions taken and all determinations made in good faith by the Administrative Committee or by other Plan fiduciaries shall be final and binding upon all persons claiming any interest in or under the Plan.

ARTICLE XV. ERISA RIGHTS

As a participant in the Plan, each Eligible Employee is entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's main office, all Plan documents including copies of all documents filed by the Plan with the U.S. Department of Labor.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report if the Plan Administrator is required to prepare such a summary annual report under ERISA. If applicable, the Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants and

beneficiaries. No one, including his Employer, may fire an Eligible Employee or otherwise discriminate against him to prevent such Employee from requesting a Benefit or exercising his rights under ERISA.

If a claim for Benefits is denied in whole or in part, the participant must receive a written explanation of the denial in accordance with the Plan's claims review procedures. The participant has the right to have the Plan review and reconsider the denied claim.

Under ERISA there are steps Plan participants can take to enforce the above rights. For example, if the participant requests materials from the Plan and does not receive them within thirty (30) days, he may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to $100 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the participant has a claim for Benefits which is denied or ignored, in whole or in part, he may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a participant is discriminated against for asserting his rights, he may seek assistance from the U. S. Department of Labor or may file suit in federal court. The court will decide who should pay for legal costs and fees. If the participant is successful in his lawsuit, the court may require the other party to pay the participants legal costs, including attorneys' fees. If the participant loses, the court may order that he pay these costs and fees, for example, if it finds that the participant's claim is frivolous.

If participants have any questions about the Plan, they should contact the Plan Administrator. If participants have any questions about this statement or about their rights under ERISA, they should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

ARTICLE XVI. ERISA INFORMATION

Plan Sponsor: Memorial Hermann Healthcare System
7737 Southwest Freeway, Suite 415
Houston, Texas 77074
(713) 776-5664

Plan Administrator: The Plan Sponsor

Agent for Service of Legal Process: Chairperson of the Administrative Committee

Plan Name: Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare System

Plan Type: Employee Welfare Benefits Plan as defined in Section 3(1) of ERISA

Plan Number: 504

Third Party Administrator: WorkLink

Financing of the Benefit Plan: Self-funded from the Employer's general assets. No employee contributions are required.

IRS Identification Number of Plan Sponsor:
74-1152597

ARTICLE XVII. MISCELLANEOUS

17.1. **Incapacitation.** Every person receiving or claiming any Benefit under the Plan shall be presumed to

be mentally and physically competent and of age unless and until the Administrative Committee receives a written notice, in a form and manner acceptable to such Committee, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with his care has been appointed. If, however, the Administrative Committee should determine that, in its opinion, any person to whom a Benefit is payable under the Plan is unable to care for his affairs because of any mental or physical incapacity or incompetency or because he is a minor, any payment due (unless a prior claim therefor was made by a duly appointed legal representative of such person) may, in the discretion of the Administrative Committee, be paid to the spouse, a child, a parent, or a brother or sister, or to any person with whom he is residing, or to any other person or institution deemed by the Administrative Committee to have incurred expense for such person otherwise entitled to payment. In the event that a guardian, conservator or other person legally vested with the care of any person receiving or claiming a Benefit under the Plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator or other person, provided that proper proof of appointment is furnished in a form and manner acceptable to the Administrative Committee. To the full extent permitted by law, any payment made in accordance with this paragraph shall be a complete discharge of any liability therefor.

17.2. **No Admission of Liability.** Any Benefits awarded under the Plan shall not in any way constitute an admission of liability or responsibility by the Employer, or any other person or entity, for any Bodily Injury, Disease or Cumulative Trauma.

17.3. **Limit on Liability.** Nothing contained in the Plan shall impose on any member of the Administrative Committee nor on any Employee or member of the Board, any liability for the payment of Benefits under the Plan. The liability of an Employer for Benefits hereunder if any, shall not exceed that expressly provided for in the Plan.

17.4. **Plan Not a Contract of Employment.** Nothing contained in the Plan shall be construed as (i) a contract of employment between an Employer and any Employee, (ii) a right of any Employee to be continued in the employment of an Employer, (iii) consideration or inducement for employment with an Employer, (iv) a condition of employment between an Employer and any Employee, or (v) a limitation of the right of an Employer to discharge any Employee, with or without cause, at any lime. All Employees shall be subject to discharge to the same extent as if the Plan had never been adopted.

17.5. **Plan Not Workers' Compensation Insurance.** The Plan does not provide, nor is it intended to provide, workers' compensation insurance coverage under the Texas Workers' Compensation Act. Notwithstanding any representations that may have been made to the contrary, written, oral or implied, no representation, commitment or guarantee is made by any Employer, nor any of its officers, directors, Employees, agents or representatives, that any Benefits provided under the Plan will, in all cases, be at least equal to benefits that may have been provided pursuant to an insured arrangement under the Texas Workers' Compensation Act. Furthermore, the mere occurrence of an Occupational Injury, Disease or Cumulative Trauma will not automatically result in a Determination to pay Benefits under the Plan; all claims will be

evaluated on an individual, case-by-case basis, taking into account the exclusions described in Article IX hereof.

17.6. **Non-Alienation.** Benefits provided under the Plan shall not be subject in any manner to alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability which is for alimony or other payments for the support of a spouse or former spouse, or for any relative of the Eligible Employee, prior to actually being received by the person entitled to the Benefit under the Plan. Any attempt to alienate, sell, assign, pledge, charge or otherwise transfer or encumber any right to Benefits provided hereunder shall be void and without effect

17.7. **No Guarantee of Tax Consequences.** No representation, commitment or guarantee is made that any amounts paid under the Plan will be excludable from the recipient's gross income for any tax purpose, or that any other tax treatment will apply or be available to such person. The Employer shall withhold from Wage Continuance and other Benefits provided hereunder any taxes which it is required to withhold pursuant to applicable law or regulation.

17.8. **Severability.** In the event that any term or provision of the Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall be fully severable and shall not affect the remaining terms and provisions of the Plan, and, furthermore, the Plan shall be construed and enforced as if the illegal or invalid term or provision had not been included herein.

17.9. **Construction.** Whenever the context of this Plan so requires, the masculine gender includes the

feminine gender, and words used in the singular or plural will include the other. The words "herein," "hereof," "hereunder," and other similar compounds of the word "here" refer to the entire Summary and not to any particular article, section or provision.

17.10. **Governing Law.** The terms, conditions and provisions of the Plan shall be construed, governed and enforced under the laws of the State of Texas, except as may be superseded by ERISA or other controlling federal law. This Plan is an "employee welfare benefit plan", as defined in Section 3(1) of ERISA, as a plan maintained for the purpose of providing medical, hospital care, safety training and other benefits as provided herein.

CONCLUSION

Memorial Hermann Healthcare System is pleased to sponsor the Plan for your benefit. We value your efforts on behalf of our organization and hope that your participation in the Plan will enable you to look with continued confidence to your future with us.

Memorial Hermann Healthcare System intends to continue the Plan indefinitely, but necessarily reserves the right to amend or terminate the Plan at any time for any reason. In the case of any conflict between the terms and provisions of the Plan and the terms and provisions of this Summary, the Plan will control and govern.

APPENDIX A

SCHEDULE OF BENEFITS FOR DEATH OR DISMEMBERMENT OF EMPLOYEES

When the Administrative Committee has made a Determination to approve Compensation for an Accidental Death or Dismemberment resulting from a Bodily Injury, the Administrative Committee is authorized to pay up to the indicated multiple of the Employee's annual wages and/or salary measured in accordance with Section 8.3 of the Plan as of the date on which the Accident occurs (i.e., the "wage base" for that Employee). An Employee's full-time or part-time work status shall be taken into account for purposes of determining his wage base. All decisions concerning (i) the actual amount of Compensation payable for a given Accidental Death or Dismemberment, (ii) the wage base for a particular Employee, and (iii) the schedule of Compensation payments attributable to an Accidental Death or Dismemberment, shall be made by the Administrative Committee in the exercise of its discretion. Unless otherwise determined by the Administrative Committee in its discretion, Compensation awarded for an Accidental Death or Dismemberment shall be paid in 120 monthly installments without interest.

Type of Occurrence	Maximum Benefit
DEATH:	Up to twenty (20) times wage base, not to exceed $2,000,000.
DISMEMBERMENT:	
Loss of one member	Up to ten (10) times wage base, not to exceed $1,000,000.
Loss of two or more members	Up to twenty (20) times wage base, not to exceed $2,000,000.

Spinal cord injury resulting in permanent paraplegia within 365 days of a Bodily Injury	Up to ten (10) times wage base, not to exceed $1,000,000.
Spinal cord injury resulting in permanent quadriplegia within 365 days of a Bodily Injury	Up to twenty (20) times wage base, not to exceed $2,000,000.

"Member" means an eye, hand or foot. The Plan does not provide for Accidental Death or Dismemberment Benefits for more than one loss from a single Accident (if such occurs, the Plan will pay only the larger benefit). This Schedule of Benefits is subject to change by the Administrative Committee from time to time (see Section 8.2 of the Plan). The Participant shall not be entitled to receive any further Wage Continuance payments under the Plan for any claims or injuries in any way attributable to, arising out of, or related to his Bodily Injury that resulted in an Accidental Death or Dismemberment award hereunder on and after the date that he receives payment of the Accidental Death or Dismemberment award for that Bodily Injury, regardless of whether any such claim or injury was known or unknown, or anticipated or unanticipated.

Memorial Hermann
HEALTHCARE SYSTEM

December 1, 2000

Ms. Carol Ann Pittman
c/o Mr. Larry Thompson
Lorance & Thompson
2900 N. Loop West, Suit 500
Houston, Texas 77092

Ms. Pittman:

Please be advised the Administrative Committee has met in response to the filing, by you, of a declaratory judgment action in Galveston contesting the rights of subrogation defined in the Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare. The Committee has found as follows:

1. You have accepted the benefits of the Occupational Benefits Plan For the Employees of Memorial Hermann Healthcare System, as amended and restated effective March 1, 1998.

2. The Occupational Benefits Plan for the Employees of Memorial Hermann Healthcare System, as amended and restated effective March 1, 1998 covered John Pittman, an employee, on the date of his ~~birth~~. [death.]

3. Article XI, section 11.1 of the Benefits Plan provides:

> "In the event of any Benefit payments made under the Plan to or on behalf of any Employee, the Plan shall, to the extent of such payments, be subrogated to all the rights of recovery and other rights of the Employee arising out of any claim or cause of action which may accrue because of the alleged accidental, negligent, intentional, or tortious conduct, act, or omission of another person or entity . . . "

4. Article XI, section 11.2 provides:

> " . . . Employee and said beneficiaries promise and agree to make such action, to furnish such information and assistance, to execute and deliver any assignments, reimbursement agreements, and other instruments as the Plan Administrator may require to facilitate enforcement of the Plan's subrogation rights."

5. Article XI, section 11.3 limits the Plan's right of subrogation to amounts paid by the plan and costs of prosecuting the claim including attorney's fees.

6. The Committee determines that a reasonable construction of the Occupational Benefits Plan gives the Plan the right to require you to assign any and all claims you may have arising out of the death of John Pittman to the Plan. Accordingly, the Committee determines that the Administrator has the right to ~~ac~~[re]quire you to execute an assignment of such claims to the Plan.

7. The Committee also determines that the Plan's right to reimbursement or of any third party recovery shall be limited to the amount of the benefits paid, plus the costs of prosecuting claims against third parties, including attorney fees.

8. The Committee finds that a reasonable interpretation of the Plan is that the Plan's right of reimbursement is superior to your rights of recovery against any third party, subject to the limitation set out in paragraph 7 of this ruling.

9. The Committee determines that the Plan has the right to require you to assign all of your claims to the Plan, and thus has the right to control the prosecution of any claims you or the estate of John Pittman (employee), may have against any third party.

10. The Committee determines that the Plan has the right to control the settlement of any and all claims against third parties who might be responsible, in whole or in part, for the death of the employee, until such time as the Plan has received the reimbursements to which it is entitled under paragraph 7 of this ruling, and subject to the Plan's fiduciary obligations as set out in Article XV section 15.6 of the Plan.

Sincerely,

/s/ Carrol E. Aulbaugh
Carrol E. Aulbaugh
Sr. Vice President & CFO

CEA:vc

House Report No. 93-533; 93d Congress, 1st Session; H.R. 2

EMPLOYEE BENEFIT SECURITY ACT OF 1973

OCTOBER 2, 1973.

House Report No. **93-533;** 93d Congress, 1st Session; **H.R.** 2

Mr. PERKINS, from the Committee on Education and Labor, submitted the following

REPORT

together with

SUPPLEMENTAL, ADDITIONAL, AND INDIVIDUAL VIEWS

[To accompany H.R. 2]

The Committee on Education and Labor, to whom was referred the bill (H.R. 2) to revise the Welfare and Pension Plans Disclosure Act, having considered the same, report favorably thereon with an amendment and recommend that the bill, as amended, do pass. The amendment substitutes all after the enacting clause and inserts a substitute text which appears in italic type in the reported bill.

I. SYNOPSIS

The Employee Benefit Security Act as reported by the Committee is designed to remedy certain defects in the private retirement system which limit the effectiveness of the system in providing retirement income security. The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighed against the additional burdens to be

placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases have been minimized. Additionally, all of the provisions in the Act have been analysed on the basis of their projected costs in relation to the anticipated benefit to the employee participant. In broad outline, the bill is designed to:

(1) establish equitable standards of plan administration;

(2) mandate minimum standards of plan design with respect to the vesting of plan benefits;

(3) require minimum standards of fiscal responsibility by requiring the amortization of unfunded liabilities;

(4) insure the vested portion of unfunded liabilities against the risk of premature plan termination; and

(5) promote a renewed expansion of private retirement plans and increase the number of participants receiving private retirement benefits.

Provision is made for the imposition of criminal penalties on those willfully violating their duties under the Act. The Labor Department is given primary authority to administer the provisions of the Act, but the Committee has placed the principal focus of the enforcement effort on anticipated civil litigation to be initiated by the Secretary of Labor as well as participants and beneficiaries.

II. BACKGROUND

The private pension system is a relatively modern economic institution tracing its role as an important social and economic factor only from the mid 1940's. A variety of converging financial and social trends in our society have

created a favorable environment for the growth and expansion of private deferred compensation schemes and retirement programs in general. As our economy has matured, an ever increasing number of employers have recognized their responsibility for the physical and economic welfare of their employees, even for the years beyond retirement. Its development parallels and is a response to the transition of the American life style from its rural agrarian antecedents into its present urbanized, wage earner society. The dynamic asset growth necessary to meet its responsibilities has placed the private pension system in a position to influence the level of savings, the operation of our capital markets, and the relative financial security of millions of consumers, three of the fundamental elements of our national economic security.

The growth of the private pension movement in the United States proceeded slowly until the years preceding World War II. As the full implications of the economic changes sweeping the nation were felt, American beliefs and attitudes regarding retirement security changed. The passage of the Railroad Retirement Act and the Social Security Act marked the turning point in American thinking, and dissatisfaction with those early governmental programs contributed to an accelerated interest in private retirement plans. The wage freezes imposed during World War II and the Korean conflict focused increased during World War II and the Korean conflict focused increased attention on the deferred component of compensation as a means of avoiding the freeze restrictions.

In 1947 a series of administrative proceedings and court decisions under the National Labor Relations Act of 1935 held that pensions were a form of remuneration for the

purposes of that Act, and they accordingly became mandatory subjects of collective bargaining. (Inland Steel Company v. NLRB, 170 f.2d 247 (7th Cir. 1948), cert. denied, 336 U.S. 960 (1949)). In the same time period a Presidential fact finding commission in presenting its report on the steel industry labor dispute in 1949 stated that:

We think all industry in the absence of adequate Government programs, owes an obligation to workers to provide for maintenance of the human body in the form of medical and similar benefits and full depreciation in the form of old age retirement – in the same way as it now does for plant and machinery.

In 1940, an estimated four million employees were covered by private pension plans; in 1950, the figure had increased to almost 10 million and in 1960 over 21 million were covered. Currently, over 30 million employees or almost one half of the private non-farm work force are covered by these plans. This phenomenal expansion of coverage has been matched by an even more startling accumulation of assets to back the benefit structure. Today, in excess of $150 billion in assets are held in reserve to pay benefits credited to private plan participants.

This rapid growth has constituted the basis for legislative efforts at both the federal and state levels to assure equitable and fair administration of all pension plans.

Various aspects of pension plans have been affected to some degree by most of the major labor legislation of the twentieth century, including the National Labor Relations Act (1935), the Labor Management Relations Act (1947), and the Labor Management Reporting and Disclosure Act (1959). However, not until 1958, with the enactment of the Welfare and Pension Plans Disclosure Act, was legislation

effected which was specifically designed to exercise regulatory controls over pension and welfare funds. Based upon disclosure of malfeasance and improper activities by pension administrators, trustees, or fiduciaries, the Act was amended in 1962 to designate certain acts of conduct as federal crimes when they occurred in connection with welfare and pension plans. The amendments also conferred investigatory and various regulatory powers upon the Secretary over pension and welfare funds. In the decade since the amendments were enacted, experience has shown that, despite intermittent enforcement of the reporting requirements and the criminal provisions, the protection accomplished by statute has not been sufficient to accomplish Congressional intent.

THE EXISTING LAW

The growth and development of the private pension system in the past two decades has been substantial. Yet, regulation of the private system's scope and operation has been minimal and its effectiveness a matter of debate. The assets of private plans, estimated to be in excess of $150 billion, constitute the only large private accumulation of funds which have escaped the imprimatur of effective federal regulation.

At the federal level, there are essentially three federal statutes which, although accomplishing different purposes and vested within different federal departments for enforcement, are all compatible in their regulatory responsibilities. These are the Welfare and Pension Plans Disclosure Act (29 U.S.C. Sec. 301 et. seq.), the Labor Management Relations Act (29 U.S.C. Sec. 141, et. seq.) and the Internal Revenue Code I.R.C. of 1954, Secs. 401-404, 501-503).

A complete description of the federal regulation affecting the administration of private plans can be found in Interim Report of The Private Welfare and Pension Plan Study, 1971, Senate Report No. 92-634 of the 92d Congress 2d Session.

After a comprehensive investigation of abuses in the administration and investment of private fund assets, Congress adopted the Welfare and Pension Plan Disclosure Act in 1958. The policy underlying enactment of this Act was purportedly to protect the interest of welfare and pension plan participants and beneficiaries through disclosure of information with respect to such plans. The essential requirement of information with respect to such plans. The eseential requirement of the Act was that the plan administrator compile, file with the Secretary of Labor, and send to participants and their beneficiaries upon written request, a description and annual report of the plan. It was expected that the knowledge thus disseminated would enable participants to police their plans. The Act was amended in 1962 to make theft, embezzlement, bribery, and kickbacks federal crimes if they occur in connection with welfare and pension plans. The 1962 amendments also conferred limited investigatory and regulatory powers upon the Secretary of Labor, and required bonding of plan officials.

Experience in the decade since the passage of the above amendments has demonstrated the inadequacy of the Welfare and Pension Plans Disclosure Act in regulating the private pension system for the purpose of protecting rights and benefits due to workers. It is weak in its limited disclosure requirements and wholly lacking in substantive fiduciary standards. Its chief procedural weakness can be

found in its reliance upon the initiative of the individual employee to police the management of his plan.

The Labor Management Relations Act, Sec. 302, provides the fundamental guidelines for the establishment and operation of pension funds administered jointly by an employer and a union. The Act is not intended to establish nor does it provide standards for the preservation of vested benefits, funding adequacy, security of investment, or fiduciary conduct.

Tax deduction benefits accruing to employers are prescribed by the Internal Revenue Code under which the employer is granted a deduction within certain limits for contributions made to a qualified plan, and the investment earnings on such plans are made tax-exempt. To attain "qualified status" under the Code, the plan must be (1) for the exclusive benefit of the participants; (2) for the purpose of distributing the corpus or income to the participants; (3) established in such a manner to make it impossible for the employer to use or divert funds before satisfying the plan's liabilities; and (4) not discriminate in favor of officers, stockholders, or highly-compensated or supervisory employees.

The Internal Revenue Code provides only limited safeguards for the security of anticipated benefit rights in private plans since its primary functions are designed to produce revenue and to prevent evasion of tax obligations. The essence of enforcement under the Code lies in the power of the Internal Revenue Service to grant or disallow qualified status to a pension plan, thus determining the availability of statutory tax advantages. The Internal Revenue Service jurisdiction and enforcement capabilities are solely to allow various tax advantages to accrue to

employers who establish and maintain pension plans which can qualify for such tax benefit privileges.

In the absence of adequate federal standards, the participant is left to rely on the traditional equitable remedies of the common law of trusts. A few states, including New York, Washington, Wisconsin, Massachusetts, and California have codified existing trust principles and enacted legislation which requires in many instances a degree of disclosure similar to that required by federal statute.

The fact that statutory rules exist says little as to their efficacy in adjusting inequities that are visited upon plan participants, as evidenced by the hearings before this Committee. In almost every instance, participants lose their benefits not because of some violation of federal law, but rather because of the manner in which the plan is executed with respect to its contractual requirements of vesting or funding. Courts strictly interpret the plan indenture and are reluctant to apply concepts of equitable relief or to disregard technical document wording. Thus, under present law, accumulated pension credits can be lost even when separated employees are within a few months, or even days, of qualifying for retirement.

The proposed bill would, therefore, establish minimum standards of vesting, funding, and fiduciary and a system of compulsory benefit insurance to protect the security of pension rights.

As suggested by the President's Cabinet Committee Report of 1965; "As a matter of equity and fair treatment an employee covered by a pension plan is entitled, after a reasonable period of service, to protection of his future retirement benefit against any termination of his employment." Concern for loss of benefits by workers after long

years of labor through circumstances beyond their control was similarly expressed by President Richard M. Nixon on December 8, 1971, when, in a message to the Congress he said, "When a pension plan is terminated, an employee participating in it can lose all or a part of the benefits which he has long been relying on, even if his plan is fully vested . . . even one worker whose retirement security is destroyed by the termination of a plan is one too many."

III. MAJOR ISSUES

Although the need for legislative reform has been and continues to be widely acknowledged among all persons and sectors affected, federal mandation of essential improvements has been resisted due to the belief that such legislation might impede plan growth. However, the Committee's inquiries have revealed that the costs associated with the vesting and funding proposals in the Act are sufficiently modest as not to constitute a major impediment to plan growth. Additionally, any added cost attributable to the imposition of vesting and funding standards will innure directly to the benefit of the participants in each plan in the form of increased availability of benefits and added security.

The principal issues affecting the vital and basic needs for legislation involve consideration of the essential elements of pensions:

A. VESTING

One of the major private pension plan considerations centers around the concept of vesting. Vesting refers to the nonforfeitable right of interest which an employee participant acquires in the pension fund. The benefit credits may

vest in the employee immediately, although in most cases participants do not become eligible for vesting of benefits until a stipulated age or period of service, or a combination of both, is attained.

Upon compliance with the basic requirements of age or service, many plans will grant their participants vested rights to those benefits earned to that time. However, should employment terminate prior to such time, the employee will receive no benefits. Some pension plans, however, specify "graded" vesting formulas, whereby only a defined percentage of the accrued benefits earned will vest upon fulfillment of minimum requirements, and such percentage may increase periodically, as the employee continues in his employment and completes additional service.

Despite the recognized and acknowledged need for pension plans to provide for vesting of earned benefits, if pension promises are to be meaningful to workers, there is need for federal statutory requirements which will compel an employer to grant such vesting benefits. The difficulties and hardships resulting from non-existent or inadequate plan provisions for vesting of benefits have been vividly established by the Committee's studies and hearings.

It is noteworthy that in 1965, the President's Commission on Public Policy and Private Pensions, while acknowledging that there had been some improvement in private plans by increased adoption of vesting provisions, nonetheless found and recommended legislation to make minimum vesting provisions mandatory. That Commission concluded that "... the degree of retirement protection in private pension plans varies widely and in many cases remains quite inadequate." (President's Committee on Corporate

Pension Funds and other Private Retirement and Welfare Programs, Public Policy and Private Pension Programs: A Report to the President on Private Employee Retirement Plans, January, 1965, p. 39).

The vesting concept recommended by the Cabinet Committee suggested preference for deferred graded vesting. It specifically favored a vesting formula under which 50 percent of an accrued pension would be vested in a plan participant upon completion of 15 years of service, with rights to full vesting of accrued pension credits to occur after 20 years of service. In general, although there has been some discernible progress to permit early vesting of benefits to employees, some employers incline to defer such vesting until the employee reaches a normal or early retirement eligibility formula. This is essentially based upon the belief that it will discourage and deter such employee from leaving the job before reaching retirement age.

Despite claims by opponents that progress made in pension plan provisions to provide vesting manifest movement toward an eventual voluntary vesting system, plans involving substantial numbers of workers which contain no vesting are still not uncommon. Opponents of mandatory vesting believe that compulsory vesting provisions will discourage development of new plans and impede flexibility and latitude in formulating employee benefits because of excessive costs that are certain to result. However, in the face of Committee findings relative to projected costs to plans for imposed vesting, indications are that the resistance of opponents to universal vesting is essentially structured upon extreme reluctance to submit to governmental regulatory measures concerning pension plan administration and operations. In its final analysis,

the issue basically resolves itself into whether workers, after many years of labor, whose jobs terminate voluntarily or otherwise, should be denied benefits that have been placed for them in a fund for retirement purposes.

B. FUNDING

Another major issue in private pension plans relates to the adequacy of plan funding. "Funding" refers to the accumulation of sufficient assets in a pension plan to assure the availability of funds for payment of benefits due to the employees as such obligations arise. Today, funding of pension plans for the limited and specific purpose of qualifying for tax benefits permitted by law for contributions made is governed by statutory and regulatory requirements which are under the jurisdiction of the Internal Revenue Service (I.R.S. Code of 1954, Sections 401-404). The minimum funding rules (Treasury Regulations, Sections 1.401-404(c) (1963)) require an employer to make contributions to a pension fund, qualified by the Internal Revenue Service, of amounts at least equal to the pension liabilities being created currently, and the interest due upon those amounts of monies which reflect unfunded accrued liabilities. The inherent weakness of this required minimum funding is that the employer is not required under law to make payments toward the principal of the unfunded accrued liabilities. Without mandatory funding of past service liabilities, a pension plan may never be in a financial posture to meet its pension obligations to its employees.

The pension plan which offers full protection to its employees is one which is funded with accumulated assets which at least are equal to the accrued liabilities, and with

a contribution rate sufficient to maintain that status at all times. However, since plans are revised and amended to provide new benefits which create new and different liabilities for the plan, opponents of compulsory funding argue that it is unrealistic to expect that plans maintain a full funding status at all times. The same opposition is voiced for new plans, which invariably assume a large unfunded liability at the outset of the plan, due to the granting of credit for past service by employees to the employer.

The ineffectiveness of funding requirements was acknowledged in the President's Cabinet Committee Report of 1965, when it concluded that " . . . the minimum standards for funding under present tax law do not assure adequate funding. The setting of standards for adequate funding therefore becomes an important public concern." (Public Policy and Private Pension Programs, 1965, pp. 50-51). The promise and commitment of a pension can be fulfilled only when funds are available to pay the employee participant what is owed to him. Without adequate funding, a promise of a pension may be illusory and empty.

C. FIDUCIARY RESPONSIBILITY AND DISCLOSURE

Another area of concern of the Subcommittee has involved the conduct of administration and operations of pension plans. Of particular interest has been the course of conduct in fund transactions, the degree of responsibility required of the fiduciaries, the types of persons who should be deemed pension "fiduciaries," and the standards of accountability they shall be governed by in the management and disposition of pension funds. The only current federal requirement is that the Secretary of Labor require

fiduciaries, trustees, etc., to make disclosure of the provisions and financial operations of the pension plan under the Welfare and Pension Plans Disclosure Act.

An important issue relates to the effectiveness of communication of plan contents to employees. Descriptions of plans furnished to employees should be presented in a manner that an average and reasonable worker participant can understand intelligently. It is grossly unfair to hold an employee accountable for acts which disqualify him from benefits, if he had no knowledge of these acts, or if these conditions were stated in a misleading or incomprehensible manner in plan booklets. Subcommittee findings were abundant in establishing that an average plan participant, even where he has been furnished an explanation of his plan provisions, often cannot comprehend them because of the technicalities and complexities of the language used.

IV. COMMITTEE STUDIES AND ACTIVITIES

The General Subcommittee on labor, pursuant to House Resolution 225, 93d Congress, February 20, 1973 and a prior resolution from the 92d Congress, has conducted a comprehensive and exhaustive study of the private pension system in the United States, with particular emphasis on the impact which such plans have upon the workers covered. The Subcommittee's implementation of the House Resolutions has been a methodical collection and analysis of vital statistics and information from individual and group cases reflecting the internal administration and operations of private pension and welfare plans. An interim staff report was issued in April of 1972 and an in-depth analysis of the cost of vesting proposals was published in February of 1973.

During February, March, April and May over twenty days were devoted by the Subcommittee to taking testimony on pension reform issues. These hearings were conducted in Washington, D.C., Pittsburgh, Pennsylvania, Waterbury, Connecticut, Chicago, Illinois, South Bend, Indiana, Seattle, Washington, Honolulu, Hawaii, and San Francisco, California.

Because of the Subcommittee's concern for the cost impact of mandated vesting requirements, an outside consultant. Dr. Howard Winklevoss, Associate Professor of Insurance at the Wharton School of Finance, was retained to prepare an analysis of the various vesting cost proposals. This analysis utilized the computer facilities of both the Wharton School and the House. The complete text of this analysis was published in February 1973.

V. COMMITTEE ACTION

The Committee endorses the concept of a comprehensive private pension reform program. It believes that expeditious enactment of H.R. 2 will institute a program which will achieve a strengthening of the role played by private retirement plans within the fabric of our economic and social structures. Its most important purpose will be to assure American workers that they may look forward, with anticipation, to a retirement with financial security and dignity, and without fear that this period of life will be lacking in the necessities to sustain them as human beings within our society. The enactment of progressive and effective pension legislation is also certain to increase stability within the framework of our nation's economy, since the tremendous resources and assets of the private pension plan system are an integral part of our economy.

It will also serve to restore credibility and faith in the private pension plans designed for American working men and women, and this should serve to encourage rather than diminish efforts by management and industry to expand pension plan coverage and to improve benefits for workers.

The Committee believes that the legislative approach of establishing minimum standards and safeguards for private pensions is not only consistent with retention of the freedom of decision-making vital to pension plans, but in furtherance of the growth and development of the private pension system. At the same time, the Committee recognizes the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.

The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations. In adopting this approach, the Committee believes it has designed a bill, which, like the National Labor Relations Act, the wage-hour laws and other labor standards laws, brings the workers' interests up to parity with those of employers. This legislation strikes an appropriate and equitable balance between two opposing schools of thought – those who advocate complete and stringent control of private pensions and those who oppose any form of government supervisory or regulatory control.

The Act does provide for coverage of public employee plans under Title I but excludes them from the other substantive provisions. The Committee is convinced that legislation seeking reform in the public sector must proceed with a thorough study of the effects of such proposals. There are literally thousands of public employee retirement systems operated by towns, counties, authorities and cities in addition to the state and Federal plans. Eligibility, vesting, and funding provisions are at least as diverse as those in the private sector with the added uniqueness added by the legislative process. For this reason the Committee is convinced that additional data and study is necessary before any attempt is made to address the issues of vesting and funding with respect to public plans.

The Committee on Education and Labor ordered H.R. 2 reported unanimously on September 25, 1932.

ESTIMATE OF COSTS

In accordance with clause 7 of Rule XIII the Committee estimates that the projected cost of administering this act will not exceed that amount currently being expended for the present act.

VI. COMMITTEE VIEWS

POLICY OF "EMPLOYEE BENEFIT SECURITY ACT"

Underlying the provisions of this Act is a recognition of the necessity for a comprehensive legislative program dealing not only with malfeasance and maladministration in the plans, or the consequences of lack of adequate vesting, but also with the broad spectrum of questions such as adequacy of funding, plant shut downs and plan terminations,

adequate communication to participants, and, in short, the establishment of certain minimum standards to which all private pension plans must conform if the private pension promise is to become real rather than illusory.

DEFINITIONS

The Committee has the following technical notes concerning definitions:

The definition of "employee" is intended to encompass any person who has the status of an "employee" under a collective bargaining agreement.

The exclusion of assets of investment companies regulated under the Investment Company Act of 1940 from the definition of "fund" is not intended to exclude participating shares in an investment company held by the fund.

With respect to the term "profit-sharing retirement plan", it is intended that stock bonus, thrift and savings or similar plans with retirement features be treated as the equivalent of profit-sharing retirement plans for purposes of this Act unless expressly indicated otherwise.

With respect to the term "normal service cost", it is intended that this definition be applied consistent with such cost methods recognized by the Internal Revenue Service unless there is an effort to avoid or evade the funding requirements of this Act.

With respect to the term "non-forfeitable right" or "vested right", it is not contemplated that vesting be required in benefits such as death benefits, disability benefits, or other forms of ancillary benefits provided by the plan. The

plan may, of course, at its option, provide for vesting in such benefits.

With respect to "adequate consideration," it is intended that this term be read to include the fair market value of the use of leased property.

In formulating the definition of "multi-employer plan" the Committee was guided by the concept that such a plan, if sufficiently comprehensive in size or scope, would be unlikely to terminate because its existence did not depend on the economic fortunes of one employer or employer entity. The Committee recognized that certain single employer plans have characteristics similar to those of the multiemployer type described in the definition, but, on balance, it is believed that experience on plan terminations provides a reasonable basis for the distinction.

TITLE I – DISCLOSURE AND FIDUCIARY STANDARDS

Title I represents a major departure from current law. First, by additions to and changes in the reporting requirements designed to disclose more significant information about plans and the transactions engaged in by those controlling plan operations and to provide specific data to participants and beneficiaries concerning the rights and benefits they are entitled to under the plans and the circumstances which may result in their not being entitled to benefits. Second, by the addition of a new section setting forth responsibilities and proscriptions applicable to persons occupying a fiduciary relationship to employee benefit plans, including a "prudent man" standard for evaluating the conduct of all fiduciaries, and by barring from responsible fiduciary provisions in such plans for a

period of five years all persons convicted of certain listed criminal offenses.

REPORTING AND DISCLOSURE

The underlying theory of the Welfare and Pension Plans Disclosure Act to date has been that reporting of generalized information concerning plan operations to plan participants and beneficiaries and to the public in general would, by subjecting the dealings of persons controlling employee benefit plans to the light of public scrutiny, insure that the plan would be operated according to instructions and in the best interests of participants and beneficiaries. The Secretary's role in this scheme was minimal. Disclosure has been seen as a device to impart to employees sufficient information and data to enable them to know whether the plan was financially sound and being administered as intended. It was expected that the information disclosed would enable employees to police their plans. But experience has shown that the limited data available under the present Act is insufficient. Changes are therefore required to increase the information and data required in the reports both in scope and detail. Experience has also demonstrated a need for a more particularized form of reporting so that the individual participant knows exactly where he stands with respect to the plan – what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted. At the same time, the safeguarding effect of the fiduciary responsibility section will operate efficiently only if fiduciaries are aware that the details of their dealings will be open to

inspection, and that individual participants and beneficiaries will be armed with enough information to enforce their own rights as well as the obligations owed by the fiduciary to the plan in general.

FIDUCIARY RESPONSIBILITY

A fiduciary is one who occupies a position of confidence or trust. As defined by the Act, a fiduciary is a person who exercises any power of control, management or disposition with respect to monies or other property of an employee benefit fund, or who has authority or responsibility to do so. It is not the intent of the Committee, however, that where the sole power of control, management or disposition with respect to plan funds rests with the participants themselves, as may be the case with respect to certain plans where the participant has the sole discretion over an individual account established in his name, that such participants shall be regarded as fiduciaries. The fiduciary responsibility section, in essence, codifies and makes applicable to these fiduciaries certain principles developed in the evolution of the law of trusts. The section was deemed necessary for several reasons.

First, a number of plans are structured in such a way that it is unclear whether the traditional law of trusts is applicable. Predominantly, these are plans, such as insured plans, which do not use the trust form as their mode of funding. Administrators and others exercising control functions in such plans under the present Act are subject only to minimal restrictions and the applicability of present State law to employee benefit plans is sometimes unclear. Second, even where the funding mechanism of the plan is in the form of a trust, reliance on conventional

trust law often is insufficient to adequately protect the interests of plan participants and beneficiaries. This is because trust law had developed in the context of testamentary and inter vivos trusts (usually designed to pass designated property to an individual or small group of persons) with an attendant emphasis on carrying out the instructions of the settlor. Thus, if the settlor incldes in the trust document an exculpatory clause under which the trustee is relieved from liability for certain actions which would otherwise constitute a breach of duty, or if the settler specifies that the trustee shall be allowed to make investments which might otherwise be considered imprudent, the trust law in many states will be interpreted to allow the deviation. In the absence of a fiduciary responsibility section in the present Act, courts applying trust law to employee benefit plans have allowed the same kinds of deviations, even though the typical employee benefit plan, covering hundreds or even thousands of participants, is quite different from the testamentary trust both in purpose and in nature.

Third, even assuming that the law of trusts is applicable, without detailed information about the plan, access to the courts, and without standards by which a participant can measure the fiduciary's conduct he is not equipped to safeguard either his own rights or the plan assets. Furthermore, a fiduciary standard embodied in Federal legislation is considered desirable because it will bring a measure of uniformity in an area where decisions under the same set of facts may differ from state to state. It is expected that courts will interpret the prudent man rule and other fiduciary standards bearing in mind the special nature and purposes of employee benefit plans intended to be effectuated by the Act.

Finally, it is evident that the opeations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

It is to be noted that the definition of "employee benefit fund" excludes assets of an investment company regulated under the Investment Company Act of 1940 but any participating shares held by the employee benefit fund in an investment company are assets of the fund and subject to coverage under this section.

The Committee also has made provision for contributory plans to equitably distribute any surplus funds remaining on plan termination to the participants in accordance with their rate of contribution. This requirement is applicable only after plan assets have been used to satisfy all liabilities. The Committee believes it is unfair to permit the complete recapture by employers of surplus funds in terminated contributory plans, without regard to the fact that contributions by the workers helped to generate the surplus. The Committee wishes to emphasize that while it is not passing judgment on any particular case now pending, it has concluded that equitable principles require that this particular subject be governed by a specific rule which reflects what the Committee regards as essential protection for the interests of workers in such plans.

The principles of fiduciary conduct are adopted from existing trust law, but with modifications appropriate for employee benefit plans. These salient principles place a twofold duty on every fiduciary: to act in his relationship to the plan's fund as a prudent man in a similar situation

and under like conditions would act, and to act consistently with the principles of administering the trust for the exclusive purposes previously enumerated, and in accordance with the documents and instruments governing the fund unless they are inconsistent with the fiduciary principles of the section.

There follows a list of proscriptions which represent the most serious type of fiduciary misconduct which in one way or another has occurred in connection with some welfare or pension plans. While the magnitude of these improper practices is small in relation to the total number of plans in existence, the seriousness of the improper practices disclosed indicates the need for additional precautions to insure that these specific examples do not become general conditions. The list of proscriptions is intended to provide this essential protection.

TITLE II – VESTING

Section 201 provides that no pension plan shall require, as a condition for eligibility to participate, a period of service longer than one year or an age greater than 25, whichever occurs later; however, a plan which provides 100% immediate vesting upon entry into plan, may restrict participation to those who are 30 years of age or have three years of service, whichever occurs later.

Earlier eligibility standards were considered and appeared to impose an unwarranted additional cost on plans. Additionally, the Committee believes on the basis of substantial evidence presented that until age 25 a large portion of the work force is still transient and accounting for such emp-oyees would impose unduly burdensome and costly record-keeping requirements on plan administrators. The Committee believes

that an age 25 entry standard approaches the norm for the majority of plans today.

The exception for plans which provide 100% full vesting upon plan entry is based on the fact that such plans, like the TIAA-CREF plan for college teachers, provide earlier vesting in larger amounts than provided under the bill, and requiring such plans to install earlier membership requirements would impose burdens well beyond the minimum standards approach intended by the Committee, and might compel such plans to sacrifice immediate full vesting on plan entry.

The Act presumes that promised pension benefits are in the form of a conditional deferred wage. While popular attention focuses on the deferred wage aspect of pensions, the Act recognizes that the pension promise is conditional upon completion of minimum periods of service. The imposition of equitable standards to limit the conditions precedent to receipt of pension rights will eliminate most of the situations where workers have lost out on their pensions.

The alternative vesting standards provided for under the bill should impact individual participants on a roughly equivalent basis. The potential for manipulation by carefully shopping for the most stringent standard to limit the incidence of vesting is considered to be modest. In all cases some vesting will occur no later than 10 years after initial employment and full vesting will occur between the 10th and 15th year of employment.

The Committee has endorsed a major innovation which provides for retrospective credit in accrued benefits attributable to service rendered prior to the effective date of the vesting provisions.

TITLE III – FUNDING

The Committee believes that actuarially sound funding procedures are indispensable to effective implementation of the purposes of the Act. If employers never went out of business or terminated pension plans before they were completely funded, there would, no doubt, be no persuasive justification for funding standards aside from whatever tax considerations might be applicable. Nevertheless, employers do experience financial or economic difficulties or they undergo varying degrees of corporate reorganization, all of which can lead to premature termination of underfunded plans. A plan termination insurance program provides the essential safeguard to the rights of workers who are trapped by these unforeseen economic hazards but such a program cannot be made practical without being coupled to required standards of funding. To create a plan termination insurance program without appropriate funding standards would permit those who present the greatest risk in terms of exposure to benefit at the expense of employers who have developed conscientious funding programs. The funding standards contained in the Act are designed to lessen that unnecessary exposure by requiring every plan to be funded in a manner which will fully amortize unfunded liabilities.

The basic rights granted by the imposition of vesting standards are of real benefit to the participant only to the extent that adequate provision is made to pay the benefits when due. The vesting standards may be viewed as controlling the volume of the benefit promises made by the plan and the funding provisions as controlling the quality of those promises. The Act recognizes as a basic principle that defined benefit pension plans must be funded on some

regular and current fashion. All current accruals of benefits based on current service are required to be paid for immediately. To the extent that a plan has offered benefits not based on current service, i.e. past service credit, the present value of such benefits is required to be amortized over a period of time not to exceed forty years, but over a shorter time period (not less than 30 years) if the average period remaining until retirement is very short.

TITLE IV – PLAN TERMINATION INSURANCE

Section 401. – Establishment and Applicability of Program

The bill reported by the Committee requires plan termination insurance to cover unfunded vested liabilities incurred prior to, as well as subsequent to, enactment of the Act, in order to prevent employees from being deprived of insurance protection for retirement credits earned before enactment.

The Secretary may provide insurance to plans to cover unfunded vested liabilities of a plan not subject to the Act so long as there is compliance with the vesting, funding and other requirements of the Act and the plan pays the requisite assessments and premiums. This is intended to make insurance coverage under the Act available on a voluntary basis to plans not subject to the Act.

Section 403. – Assessments and premiums

The Committee adopted a provision which requires an initial three-year premium to be paid by the plan, as follows:

(a) For funded vested liabilities incurred after enactment – 0.2 percentum of unfunded vested liabilities;

(b) For unfunded vested liabilities incurred prior to enactment – 0.2 percentum of unfunded vested liabilities provided the plan was 75 percent funded during the five-year period preceding Act, or if the plan is less than five years old on date of enactment, and if it was reducing unfunded vested liabilities at rate of five percent each year;

(c) For unfunded vested liabilities incurred prior to Act, but where the funding tests above in (b) have not been met – more than .4 percentum and not less than 0.2 percentum of such unfunded vested liabilities;

(d) As to multi-employer plans, both as to unfunded vested liabilities incurred before or after Act – not to exceed 0.2 percentum of all such unfunded vested liabilities.

In order to minimize the risk of shifting to the reinsurance program substantially all unfunded liabilities created prior to enactment, it was believed essential to create two classes of risks for purposes of setting the premium rate. If the plan was being funded in an adequate fashion, i.e., was 75 percent funded or was amortizing unfunded vested liabilities at the rate of five percent each year, it was believed that such a plan was an acceptable risk and the .2 percentum premium rate was appropriate. In the event the plan did not meet the test of funding adequacy, as indicated, it falls in the category of being a higher risk and therefore, can be charged up to twice the amount of normal premium, but no more. Since multi-employer plans, as defined in the bill, have a much lower risk of plan termination, it was believed appropriate to continue charging the .2 percent premium regardless of when the unfunded vested liabilities were incurred.

Section 404. – Payment of Insurance

There are a variety of circumstances under which pension plans terminate. In some cases, the termination proceeds by stages. In other cases, it may happen fairly rapidly. In order to carry out the purpose of the reinsurance program while at the same time protecting the program from undue exposure owing to delays, manipulation, or unforeseen economic hazards following plan termination, the Secretary is provided with sufficient flexibility to determine the most appropriate procedure for winding up terminated plans and assuring effective implementation of the insurance program.

It is also required that plans furnish to the Secretary adequate prior notice of intent to terminate the plan. Persons responsible for giving such notice who fail to do so, or who terminate plans in order to circumvent or avoid the Act, are held personally liable for losses sustained by the insurance program.

Section 405. – Recovery

The Committee recognizes that in order to provide adequate protection to employees against loss of vested benefits owing to premature plan termination, it is necessary for the insurance program to cover all forms of plan termination regardless of the circumstances giving rise to the termination. The Committee also recognized that some degree of employer liability was essential where the employer was not insolvent at the point of plan termination in order to preclude abuse by shifting the financial burden to the plan termination insurance program despite the fact that the employer had available funds to continue funding the plan.

One approach to this problem would be to require financially responsible employers to, in effect, act as self-insurers for the unfunded vested liabilities and those who are not financially responsible to obtain plan termination insurance. This approach, which is supported by precedent in the field of workmen's compensation, for example, was considered and rejected because of the potentially enormous liabilities involved. To require the Secretary to evaluate the financial capabilities of particular employers to assume such potentially enormous liabilities might have an adverse effect on the employer's competitive position and on his continued healthy growth.

Having determined that participation in the plan termination insurance program was essential for all plans, and that some degree of employer liability was necessary, the question of the degree of such liability becomes important. The Committee had concern that if the degree of liability was absolute to the extent of the employer's assets, it might drive some employers to the brink of bankruptcy, impose substantial economic hardship, or discourage the establishment of plans or the reasonable liberalization of benefits.

Accordingly, the Committee endorsed a formula of employer liability which requires the employer to reimburse the plan termination insurance program for the total amount of insurance paid, but in no event greater than 50% of employer's net worth at time of plan termination,

In addition, as a result of plan termination field hearings held by the Subcommittee, numerous instances were disclosed where acquiring companies that terminated pension plans failed to take over the liability for vested benefits owed to the employees of the predecessor company. Since this

circumstance could also arise in connection with the reinsurance provision, it is necessary to strengthen the reinsurance provisions by requiring successors-in-interest to be liable for reimbursements owned by predecessor companies.

In order to make the liability of the employer for reimbursement of insurance paid meaningful, it was considered essential to provide a mechanism for enforcement of such liability through giving the government a lien on employer property for unpaid amounts due.

With respect to the Secretary's authority to treat portions of multiemployer plans as terminated for purposes of applying the plan termination insurance provisions, it should be noted that the contributing employers in such arrangements are free to arrange indemnification agreements among themselves in connection with the plan's application for insurance coverage under Title IV, so that employer liability for reimbursement of insurance paid under Title IV can be allocated under terms that the parties themselves have agreed to as equitable.

TITLE V – ENFORCEMENT

The enforcement provisions have been designed specifically to provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of the Act. The intent of the Committee is to provide the full range of legal and equitable remedies available in both state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law for recovery of benefits

due to participants. For actions in federal courts, nationwide service of process is provided in order to remove a possible procedural obstacle to having all proper parties before the court.

Except where plans are not subject to this Act and incertain other enumerated circumstances, state law is preempted. Because of the interstate character of employee benefit plans, the Committee believes it essential to provide for a uniform source of law in the areas of vesting, funding, insurance and portability standards, for evaluation of fiduciary conduct, and for creating a single reporting and disclosure system in lieu of burdensome multiple reports. As indicated previously, however, the Act expressly authorizes cooperative arrangements with state agencies as well as other federal agencies, and provides that state laws regulating banking, insurance or securities remain unimpaired.

The Act makes it unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of the plan or the Act, or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan or the Act.

The Act makes it a criminal offense for any person to use fraud, force, or violence or threats thereof to restrain, coerce, intimidate or attempt to restrain, coerce, intimidate any participant or beneficiary for the purpose of interfering with or preventing the exercise of any right to which he is or may become entitled under the plan, or the Act.

Although the instances of these occurrences are relatively small in number, the Committee has concluded that

safeguards are required to preclude this type of abuse from being carried out and in order to completely secure the rights and expectations brought into being by this legislation.

VII. SECTION-BY-SECTION ANALYSIS

PURPOSES

The Employee Benefit Security Act is designed (1) to establish minimum standards of fiduciary conduct for Trustees, Administrators and others dealing with retirement plans, to provide for their enforcement through civil and criminal sanctions, to require adequate public disclosure of the plan's administrative and financial affairs, and (2) to improve the equitable character and soundness of private pension plans by requiring them to: (a) vest the accrued benefits of employees with significant periods of service with an employer, (b) meet minimum standards of funding and (c) guarantee the adequacy of the plan's assets against the risk of plan termination prior to completion of the normal funding cycle by insuring the unfunded portion of the benefits promised.

Section 2. Findings and declaration of policy

Section 3. Definitions:

1. Employee Welfare Benefit Plan
2. Employee Pension Benefit Plan
3. Employee Benefit Plan (or Plan)
4. Employee Organization
5. Employer
6. Employee

7. Participant
8. Beneficiary
9. Person
10. State
11. Commerce
12. Industry or Activity Affecting Commerce
13. Secretary
14. Party in interest
15. Relative
16. Administrator
17. Separate Account
18. Adequate Consideration
19. Nonforfeitable (Pension Benefit or Right)
20. Security
21. Fiduciary
22. Regular Retirement Benefit
23. Accrued Portion of the Regular Retirement Benefit
24. Regular Retirement Age
25. Vested Liabilities
26. Current Value
27. Present Value
28. Investment Company not a Fiduciary

29. Normal Service Cost

30. Present Value of an Annuity Certain

31. Accrued Liability

32. Multi-Employer Plan

33. Unfunded Accrued Liability

34. Advanced Funding Actuarial Cost Method (Actuarial Cost Method)

TITLE I – FIDUCIARY RESPONSIBILITY AND DISCLOSURE

Section 101. Coverage

Title I would cover all private employee benefit plans under Commerce Clause jurisdiction except:

1. Plans of the Federal government;

2. Plans required under workmen's compensation, unemployment compensation, and disability insurance laws;

3. Plans established or maintained outside the United States for the benefit of non-United States citizens;

4. Unfunded deferred compensation schemes of top executives.

Section 102. Duty of disclosure and reporting

The administrator of a pension or welfare plan would be required to publish to each participant or beneficiary a description of the plan as set forth in section 103 and a summary of the annual financial report as set forth in section 104. The report would be in such form and detail

as the administrator finds necessary to disclose fully and fairly all pertinent facts.

Upon termination of a pension or welfare plan, the administrator would be required to file a special terminal report as prescribed by the Secretary of Labor.

Section 103. Description of the plan

Plan descriptions would be required to be published within 120 days after the establishment of a plan or within 120 days after a plan becomes subject to this title, whichever is later. Amendments to plans would have to be published within 120 days, and descriptions would have to be republished at least every five years. The description would have to be comprehensive and written in a manner calculated to be understood by the average plan participant. Among other things it would have to include: the name and address of the administrator; the schedule of benefits; a description of the plan's vesting provisions; the source of the plan's financing; and the procedures to be followed in presenting claims for benefits as well as those for appealing claims which are denied.

Section 104. Annual reports

An annual financial report to the Secretary of Labor would be required by this section for all plans. Sec. 105 provides that the Secretary shall exempt plans with less than 26 and may exempt plans with less than 100 participants. Information required in the report would include:

An audit and opinion by an independent qualified public accountant (with exceptions for public plans and when financial statements are certified by a bank or insurance carrier);

An actuarial statement of valuation (where appropriate) accompanied by a certification from the actuary preparing the valuation;

The number of employees, benefits paid, and information fiduciaries, trustees and administrators and compensation paid them;

A summary financial statement of assets and liabilities;

A summary of receipts and disbursements;

A schedule of all assets listed by issuer;

A schedule of known party-in-interest transactions;

A schedule of loans which are in default and uncollectible;
A schedule of leases which are in default and uncollectible;

A bank or insurance carrier statement of assets and liabilities for common and collective trusts.

If some or all of the plan's assets are held in common or collective trust maintained by a bank or similar institution or in a separate account maintained by an insurance carrier, the bank or carrier would also be required to file a statement of assets and liabilities.

If some or all of the benefits under the plan are provided by an insurance carrier or other organization, such report would also have to include: The premium rate or subscription charge and the total premium or subscription charges paid to each carrier and the approximate number of persons covered by each class of benefits; the total premiums received, the approximate number of persons covered by each class of benefits, and the total claims paid by such carriers, or, if separate experience ratings are not kept, a

statement as to the basis of a carrier's premium rate or a copy of the financial report of the carrier.

Section 105. Publication

The Secretary would be authorized to reject any report which after a hearing before him was found to be incomplete or to contain a qualified opinion by an accountant or an actuary.

A copy of the plan description and each annual report would have to be filed with the Secretary of Labor who would make them available for inspection in the public document room of the Department of Labor. The administrator would be required to make copies of the annual report and plan description as well as the bargaining agreement, and trust instrument creating the plan available for examination by any plan participant or beneficiary in the administrator's principal office, and in such other places as necessary to fully and fairly disclose all pertinent facts.

All pension and welfare plan participants would be furnished with a copy of the plan description initially and at the time of amendment, including:

A schedule of benefits;

Eligibility and vesting provisions;

Claim procedures and remedies;

Basis of financing;

Other relevant plan provisions affecting their rights and the annual report, including a summary financial statement of assets and receipts and disbursements, and the ratio of assets to value of nonforfeitable pension benefits.

Upon written request to the plan administrator, a participant could receive a copy of a statement as to his or her rights and the amount of any nonforfeitable benefit; and a copy of the plan, trust, bargaining agreement or other document. All newly vested would receive notification at the time their benefits became nonforfeitable. These copies would be furnished at the cost of reproduction.

Upon termination, all pension plan participants would receive a statement showing his or her benefits, indicating when and how they may be claimed, and including any other information affecting their rights.

A statement of a pension plan participant's right to deferred vested benefits from former pension plans would be furnished upon request to the Social Security Administration and when action is taken on the participant's Social Security account. To assure timely filings and payment of vested benefits, the address and identity of all plans would be kept up-to-date.

Section 106. Disclosure of benefit rights to participants

The administrator is required to inform each participant when his benefits become nonforfeitable. Upon written request of any participant or beneficiary, the administrator is required to disclose the rights of that participant.

Violation of the provisions dealing with the retention of records subjects a person to a fine of up to $5,000 and/or imprisonment of up to two years. Violations of the provisions of 111(b) (2) (dealing with prohibited transactions) would subject a person to a fine of up to $10,000 and/or up to five years' imprisonment.

This section would give the Secretary of Labor authority to investigate any plan. He would be given authority to

demand sufficient information as he may deem necessary to enable him to conduct his investigations.

Plan participants, beneficiaries, or the Secretary of Labor on behalf of the participants and beneficiaries would be allowed to bring civil actions to redress breaches of a fiduciary's responsibility or to remove a fiduciary who has failed to carry out his duties. The Secretary would also be empowered to bring an action to enjoin any act or practice which appears to him to violate the title. Civil actions brought by a participant or beneficiary may be brought in any court, State or Federal. However, the Secretary would have the right to intervene in a case and remove it to a Federal district court. In any actions by a participant or beneficiary, the court could, at its discretion, allow reasonable attorneys' fees and costs of action to either party. Class actions shall be brought where requirements for class actions could be met.

Section 107.

All reports filed with the Secretary shall be public information.

Section 108.

Detailed records must be retained for six years.

Section 109.

Proven reliance upon a regulation or written interpretation by the Secretary of Labor would constitute a defense in a criminal or civil proceeding under certain sections of the Act.

Section 110.

Every person subject to the fiduciary provisions of the act would have to be bonded.

Section 111. Fiduciary responsibility

This section would deem every employee benefit fund to be a trust held for the exclusive purpose of providing benefits to participants and their beneficiaries as well as defraying reasonable administrative expenses. Each plan would have to be in writing.

A fiduciary is defined in section 3 (29) as anyone who exercises any power of control, management or disposition with regard to a fund's assets or who has authority to do so or who has authority or responsibility in the plan's administration. Fiduciaries would be required to discharge their duties with respect to the fund " . . . solely in the interest of the participants and with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."

A fiduciary would also have to diversify the investments, except in the case of profit-sharing, stock bonus, or thrift and savings plans, so as to minimize the risk of large losses unless under the circumstances it is prudent not to do so and in accordance with the documents and instruments governing the fund,

A fiduciary would be specifically prohibited from making the following transactions: Dealing with such fund for his own account . . .

Acting in any transaction involving the fund on behalf of a party adverse to the interests of the plan or participants . . .

Receiving personal consideration from any party dealing with the fund in connection with a transaction involving the fund . . .

Transferring property to any party in interest for less than adequate consideration . . .

Permitting the acquisition of property from any party in interest for more than adequate consideration.

Section 112. Pension plan termination

An equitable priority distribution of assets would be provided upon plan termination. Assets not previously allocated to individual accounts would have to be distributed according to the following priorities:

(a) Contributions by employees would be returned;

(b) Those presently receiving benefits and those who could voluntarily elect to receive benefits;

(c) Those other than in (b) – to the extent of their vested benefits;

(d) All others, including the non-vested benefits of those in (c).

Benefit increases within the five years prior to plan termination would trigger an allocation based on the prior benefit formula, any remaining assets being distributed on the basis of increases in the more recent benefit formulas:

(e) Investment income attributable to employee contributions would be distributed pro rata to the employees' accounts.

(f) Any benefit liabilities incurred as a result of plan termination would be given last priority.

(g) Any remaining assets would be returned to the employer if the plan so provides; otherwise, they would be distributed proratably to the employees.

Section 113.

Certain persons convicted of crimes may not serve as officers, administrators, trustees, or paid consultants.

Section 114.

A 15-member Advisory Council on Employee Welfare and Pension Benefit Plans would be established.

Section 115.

The Welfare and Pension Plans Disclosure Act would be repealed upon the effective date of the act, which would be six months after enactment.

TITLE II – VESTING AND ELIGIBILITY REQUIREMENTS

Section 201. Coverage

Title II would cover all private pension benefit plans including profit-sharing plans which provide benefits after retirement, except:

1. Federal, State and local plans;

2. Keogh plans benefiting the self-employed and owner-employees;

3. Plans established or maintained outside the United States for the benefit of workers who are not United States citizens;

4. Executive deferred compensation plans; and

5. Secondary plans providing class year vesting.

Section 202. Eligibility requirements

No plan, after the effective date of this title, would be allowed to require as a condition for eligibility to participate in it an age greater than 25 or a period of service longer than one year (three years for plans which provide for immediate 100% vesting or for crediting of all preparticipation service for benefit purposes), whichever is the later. Existing plans would be permitted to retain their eligibility requirements for three years or until they are amended, whichever is sooner.

Section 203. Nonforfeitable benefits

Every pension plan would be given a choice of one of three vesting rules:

1. Ten-Year Service Rule (100% vested at 10 years of covered service);

2. Graded Fifteen-Year Service Rule (30% vested at eight years of covered service, such percentage increasing by 10% each year until 100% is reached after 15 years of covered service);

3. Rule of 45 (50% vested when age plus covered service equals 45, such percentage increasing by 10% each year until 100% is reached).

The vesting rules use a fully retroactive service provision in calculating the vesting percentage and the amount of the accrued portion of the regular retirement benefit. A plan would be permitted to change vesting rules at any time if provision is made that vested benefits not be reduced or delayed for participants in the plan at the time of change. A plan would always be permitted to allow for vesting of benefits after a lesser period and in a greater amount than is required under any of the three vesting rules.

Class year profit-sharing plans. – Class year plans would be required to vest 100% of the employer's contribution no later than five years after the contribution was made.

Covered service. In computing the period of covered service under a plan, an employee's entire service with the employer contributing to or maintaining the plan shall be considered. However, service prior to age 25, service during which the employee declined to contribute to a plan requiring employee contributions, service with a predecessor of the employer contributing to or maintaining the plan (except where the plan has been continued in effect by the successor employer), service broken by periods of suspension of employment (provided the rules governing such breaks in service are not unreasonable or arbitrary), and service where a participant has previously attained a 100% nonforfeitable right may be disregarded.

Contributory plans. – No plan may provide for forfeiture (1) of any employee contributions unless agreed to in writing, or (2) of the accrued portion of the regular retirement benefit to the extent that such portion is nonforfeitable and is attributable to employer contributions.

Section 204. Distribution of nonforfeitable benefits to terminating participants

Vested benefits to participants terminating before 65 would have to be distributed, at the option of the participant, at regular retirement age or age 65. Vested benefits to participants terminating after age 65 would have to commence immediately at the option of the participant. Survivor annuity and other options offered by a plan to normal retirees would have to be extended to all terminated vested participants.

Social Security offset plans. Any pension plan with a Social Security offset feature would be required at the time of the first plan amendment, to provide that the amount of any offset not increase (1) for participants receiving benefits and (2) after the date of termination of a vested participant.

Section 205. Effective date

The effective date of this title would be two years after enactment. Collectively bargained plans would be extended up to 30 additional months to conform their bargaining agreements to this title.

TITLE III – FUNDING

Section 301. Coverage

Title III would cover all private pension benefit plans covered under title II except for profit-sharing and other individual account plans and unfunded voluntary fraternal type plans.

Section 302. Minimum funding standard

Every pension plan subject to title III (other than the above) must make annual minimum contributions equal to:

1. Normal cost plus no less than 30 but no more than 40-year amortization of unfunded accrued liabilities for all plan benefits; any accumulated actuarial gains and losses would be spread over the future service of active participants;

or, if larger,

2. A percentage of the unfunded portion of the present value of the nonforfeitable pension benefits. The unfunded portion would be recalculated each year so that an interest assumption of 5% would reduce the remaining unfunded portion by about 9.2% per annum or by about 57% in 20 years or 72% in 30 years.

Contributions made in excess of the minimum could be used to offset future minimum contributions, thereby permitting funding flexibility. Required minimum contributions in excess of tax deductible limits would be permitted to be carried over to succeeding years where tax deductions would be allowed.

Section 303. Enforcement of funding requirements; variances

Application would have to be made to the Secretary for a waiver of part or all of a minimum funding contribution. Benefits could not be increased until all such waived contributions had been paid off. After five waivers in a ten-year period, the Secretary could, after notice and hearing, order the termination of the plan or the merger of the plan

with another plan of the employer. Benefits could not be increased by amendment during a period of waiver.

Section 305. Effective date

The effective date of this title would be two years after enactment. Collectively bargained plans would be extended up to 7 years to conform their bargaining agreements to this title.

TITLE IV – PLAN TERMINATION INSURANCE

Section 401.

This section establishes a Private Pension Plan Termination Insurance Program administered by the Secretary, which requires plans to insure unfunded vested liabilities incurred prior to enactment of the Act, as well as after enactment of the Act. The Secretary may provide insurance to cover unfunded vested liabilities of a plan not subject to the Act where he determines that such plan conforms to the vesting, funding and all other standards required by the Act.

Section 402. Conditions of insurance

This section requires the insurance program to insure participants against loss of vested benefits arising from plan termination.

The amount of vested benefit insurance is limited to 50 percent of highest average monthly wage of participants earned over a five year period, or $500 monthly, whichever is the lesser.

No insurance shall be paid if the plan is terminated less than three years from date of establishment or registration unless the Secretary determines that a registered

plan was otherwise in substantial compliance with the Act and that the reserve position of the insurance program will not be adversely affected.

Insurance will not cover vested rights created by any plan amendment which took effect less than three years prior to plan termination.

No coverage is extended to participants who own 10 percent or more of employer voting stock.

Section 403. Assessments and premiums

This section requires plans to pay an initial uniform assessment to be prescribed by the Secretary to cover administrative costs of the program. The Secretary shall prescribe an annual premium rate based upon unfunded vested liabilities. For the first three years, the insurance premium shall not exceed 0.2 percent of unfunded vested liabilities incurred after enactment of the Act. With respect to those unfunded vested liabilities incurred prior to enactment the premium shall be 0.2 percent provided that the unfunded vested liabilities of the plan were funded at least 75% during the five-year period preceding enactment.

As to plans which on date of enactment were less than five years old, the premium shall be 0.2 percent, provided that the plan had been reducing its unfunded vested liabilities at a rate of no less than 5 percent annually. In the event plans do not meet the above funding standards, they can be charged a premium not to exceed 0.4 percent or less than 0.2 percent of pre-enactment unfunded vested liabilities.

Also, in the case of multiemployer plans (as defined in the Act), the premium rate for the initial three years shall not

exceed 0.2 percent of unfunded vested liabilities, regardless of when such liabilities were incurred.

After the initial three-year period, the Secretary may prescribe an annual rate based upon experience, and unless Congress objects within 90 days, the new premium shall become effective.

The Secretary is required to consult with appropriate private and government agencies on matters relating to the assessment and premium rates before prescribing rates.

Section 404. Payment of insurance

This section requires that plans must notify the Secretary of intent to terminate, and failing to do so will make such persons personally liable for any losses incurred by the Pension Benefit Insurance Fund in connection with plan termination.

The insurance to be paid shall be the difference between the plan's assets and unfunded vested benefits owed at the time of plan termination.

In addition, the Secretary is required to prescribe procedures under which funds of terminated plans shall be liquidated and paid out to cover vested benefits of participants. In implementing this authority, the Secretary may transfer terminated funds under his supervision or purchase annuities from qualified insurance carriers for participants or take such other action as may be appropriate. Persons who terminate a plan with intent to circumvent the Act or the WPPDA shall be personally liable for losses.

Section 405. Recovery

This section provides that, where employers in terminated plans are not insolvent, they or their successors-in-interest may be liable for reimbursement of a portion of insurance benefits paid. The liability of the employer is to pay 100% of the unfunded vested liabilities and in no event shall it exceed 50% of the employer's net worth.

The Secretary shall make arrangements with employers on equitable terms for the reimbursement of insurance paid.

The amount or amounts of any unpaid liability owned by an employer shall constitute a lien in favor of the government, but junior to any lien for unpaid taxes owed to the government.

Section 406. Pension Benefit Insurance Fund

This section establishes within the Labor Department a fund for the deposit of premiums, assessments, etc., made under the Act and for payment of such claims thereunder.

TITLE V. GENERAL PROVISIONS

Section 501. Variations; Appeals Board

The Secretary is authorized to grant variations from the requirements of titles II and III and Section 112. A Variation Appeal Board would be established to hear and determine appeals from decisions denying grants of variations.

Section 502. Studies

This section directs the Secretary to conduct research relating to the effects of the act, the role of private pensions, the

operation of public and private pension plans, and methods to encourage the growth of the private pension system.

Section 503. Enforcement

This section would give the Secretary authority to conduct such investigations as may be necessary to determine whether any person has violated or is about to violate any provisions of title II or III or any rules or regulations which would result from enactment of titles II and III. Information about such investigations would be made available to any interested person and included in an annual report by the Secretary. Criminal penalties of five years imprisonment and $10,000 fine or up to a $200,000 fine in the case of a corporate felon would be assessed for willful violation of the Act. Civil actions by the Secretary, participants or beneficiaries to enforce the provisions of the Act are authorized in Federal Court.

Section 504. Annual report of the Secretary

The Secretary would be required to submit an annual report to the Congress covering his administration of the Act.

Section 505. Rules and regulations

This section would authorize the Secretary to prescribe such rules and regulations as he finds necessary to carry out the provisions of the Act.

Section 506. Other agencies and departments

The Secretary would be authorized to enter into agreements that would avoid unnecessary expense and duplication and would permit cooperation among government agencies in performing his functions under title II, or III.

He would also be authorized to reimburse other Federal agencies for facilities or services he utilized in doing so. The Attorney General would be authorized to receive such evidence as developed by the Secretary which may be found to warrant consideration for criminal prosecution.

Section 507. Administration

Chapters 5 and 7 of Title 5, United States Code (relating to administrative procedure) would be applicable to this Act.

No employee of the Department of Labor would be able to administer or enforce the Act with respect to any employee organization of which he is a member or employer organization in which he has an interest.

Section 508. This section would authorize to the Secretary such sums as may be necessary to carry out this Act

Section 509. If any provision of this Act were held invalid, the remainder of the Act would not be affected

Section 510. Interference with the rights protected under the Act would be unlawful. – The provisions of sections 404 and 405 would be applicable in the enforcement of this section

Section 511.

Any person who used coercion to interfere with the rights protected under the act would be subject to a $10,000 fine and/or imprisonment for up to one year.

Section 512. Registration

Within six months after the effective date of titles II and III, each pension and profit-sharing plan would have to file

an application with the Secretary of Labor for qualification and registration. Plans established after that date would have six months in which to file such application. Plan amendments similarly would have to be reported to the Secretary. A certificate would be issued and continued in force so long as the eligibility, vesting and funding requirements of the Act are met.

Section 513. Enforcement of Registration

The Secretary of Labor may seek a court order to secure compliance whenever a determination is made that no application for registration has been filed, that the application should be denied or the registration cancelled, or that a plan has failed to make the required contributions or to pay such other assessments or fees as are required.

Section 514. Effect on other laws

All State laws would be pre-empted except for those covering plans not subject to titles II and III.

* * *

Albert H. Quie

John M. Ashbrook

John N. Erlenborn

Edwin D. Eshleman

Orval Hansen

Marvin L. Esch

SUPPLEMENTAL VIEWS

First, we are satisfied that, after extended hearings and serious discussion, the committee bill generally is a good bill.

However, our deliberations have not led to full or complete agreement on the question of the necessity, economic desirability, cost or legal correctness of plan termination insurance. Initially, provision for this type of insurance was made in a separate bill (H.R. 462) because, without additional information, agreement on this provision (Title IV) was not possible.

Our primary consideration in writing pension reform legislation has been to help assure that workers now covered by pension plans get their expected benefits. At the same time, we have been careful not to inhibit benefit improvements for these covered workers and not to retard the expansion of the pension system in such a way as to deny retirement benefits to workers not now covered.

Accordingly, we reasoned that, by requiring stringent vesting and funding standards, the need for insurance could be realistically negated. Further, inasmuch as it was recognized by the Members of the Committee that legislation could not eliminate all plan terminations, we agreed that the possible losses due to any termination would be mitigated to considerable extent by including provisions in the bill:

(a) to prevent dilution of benefit security in business acquisition and merger situations;

(b) to provide for partial plan terminations with the approval of the Secretary of Labor;

(c) to provide fund distribution priorities on termination so there will be a more equitable distribution of all assets;

(d) to prevent "raiding" of assets by participants who leave the plan.

The Committee provision to impose a premium to insure the benefit already being funded on a sound actuarial basis creates an employer liability for the benefit if not funded, and thus radically changes the basic legal structure of all plans. It also increases the cost of funding by the amount of the premium rate, which at this time is not susceptible of determination, but is only estimated.

Because the determination of insufficient funding would in substantial part stem from market value losses of plan assets, the Committee bill is, in effect, insuring against fluctuations in the market. We know of no counterpart obligation in business compelling such insurance.

Additionally, we do not believe it possible to provide such a guarantee without ultimate reliance on the Federal treasury.

Finally, Title IV raises a serious constitutional question as to whether by legislation we can change the contract of the employer from a promise to make certain contributions to a fund to a promise to pay the pension supported by a pledge of the employer's assets.

Title IV would require that an employer reimburse the insurance fund for 100% of any amounts paid out by the fund, up to an amount equal to 50% net worth of the employer. Accordingly, on passage of the Committee bill, an employer would be obligated to carry that liability in his balance sheet. This contingent liability would be such as to make the financial structure of any business appear

unsound. Such liability would inevitably discourage additional employers from beginning new pension plans and existing plans from increasing benefits and thereby increasing the employer's liability.

In summary, other provisions of the Committee bill impose minimum eligibility and vesting, require adequate funding, and prevent other events which could dilute benefit security. We believe these additional standards should be effectuated and the need for insurance re-assessed. Pending such re-assessment, Title IV should be deleted.

ALBERT H. QUIE.

JOHN M. ASHBROOK.

JOHN N. ERLENBORN.

EDWIN D. ESHLEMAN.

ORVAL HANSEN.

ADDITIONAL VIEWS

As indicated by my vote to report H.R. 2 out of Committee, I favor legislation to provide reasonable pension protection for the 35 million people enrolled in private pension plans. However, I believe employees covered by State and local government retirement plans are entitled to similar protection, and I fail to understand the Committee's unwillingness to provide them that protection.

To the Committee's credit, it was agreed that public retirement plans should meet the bill's fiduciary standards and requirements for disclosure of information to participants. Minimum vesting and funding standards were rejected, however – the former in the assumption that most public plans provide adequate vesting, and the latter

on the grounds that State and local governments and their taxing authority will be with us forever.

Public plans, for the most part, are known to be generous so far as vesting is concerned. Unfortunately, statistics are not available to support this assumption. Notwithstanding this lack of data, my point is that no public employee should be denied the minimum vesting rights the Committee bill asserts every private employee deserves.

The Committee bill provides for a study of these plans. Yet I am constained to point out that the original version of H.R. 2 would have covered these plans and that, in the course of our hearings on pension reform, we did invite interested parties to testify. Only a few accepted the invitation, but those representatives of public employee organizations, legislators, and actuaries who did submit testimony on this aspect endorsed the blanketing of public employees under Federal pension legislation. In spite of this support for inclusion, and with no apparent justification, the provision was dropped.

Presumably, the study recommended in the bill will reveal the funding status of various State and local plans. I submit that public plans are as notorious for their pay-as-you go, or worse, funding schemes as they are for their comparative generosity in vesting.

Proof of concern by the participants themselves can be found in the courts. Public employees in Philadelphia, for example, have filed suit to compel adequate funding of a $36 million liability. In Detroit, a similar suit involves an $18.2 million liability; and, in my own State, the Illinois Education Association successfully conducted legal action to bring about sounder financing of a $1.7 billion unfunded

past service liability together with current liabilities for new benefits.

The seeming perpetual life of the States and their political subdivisions gives us a false confidence, as these court cases attest. Acceptance of the premise that these governments will not go out of business as an argument against funding only postpones the inevitable.

At Thomas Bleakney, a respected actuary and author of Retirement Systems for Public Employees, points out, "The basic argument for funding with respect to public systems, in my opinion, is honesty in government – the cost of any governmental service should be known (and paid for) when the service is provided, and not ignored to be paid for at some future date."

Absent funding, which permits taxpayers to know the effect of new benefits on the government's budget, there is a decided tendency on the part of elected officials to increase benefits substantially and to leave the day of reckoning to their successors. Compounding the problem is the fact that these elected officials are frequently beneficiaries of these plans and so are in the position of negotiating from both sides of the bargaining table.

Not inconceivably, when the already burdened taxpayer is awakened to the true scope of this obligation, objection by court challenges could leave the security of the expected benefits in doubt, if not non-existent.

Court challenges, and the possible loss of benefits, could emanate as well from the premise that an unfunded public retirement plan amounts to deficit financing. Unlike the Federal Government, States are generally prohibited from operating with a deficit and from borrowing to balance the

budget. By deferring until another day pension promises made today, a debt is undeniably created.

In some cases, the sudden imposition of a minimal funding requirement on public plans such as that recommended in H.R. 2 for the private sector could create a considerable burden for taxpayers. I do not suggest that identical rules apply to the public sector; but a separate, graded funding formula would mitigate this possibility.

In short, the Committee missed the opportunity in H.R. 2 to foster honesty in government and to give public employees the comprehensive protections and guarantees we deem vital to private employees. To do so is a mistake at the expense of taxpayers and State and local employees.

JOHN N. ERLENBORN, Member of Congress.

INDIVIDUAL VIEWS

H.R. 2 addresses itself to the fundamental concern of pension reform and insofar as the provisions extend, I am in general support of the action taken by the full Committee in reporting out this legislation.

However, I believe there are a number of areas which must be more carefully thought out in the days ahead if this Congress is to truly guarantee the rights of the American worker to a retirement free from financial worry.

In the area of reinsurance, the provisions in H.R. 2 would insure pension benefits in the event of program failure. If we are to truly have a "Retirement Bill of Rights" then we must recognize the inherent interdependence of the reinsurance program, the vesting and other provisions of any proposed legislation. To delete reinsurance would be to

create a faulty and untested mechanism of guaranteeing pension benefits.

Earlier this session, I introduced H.R. 9999, the Omibus Pension Security Act. While several provisions of H.R. 9999, including reinsurance, are included in H.R. 2, there are significant factors that must be considered by the House if we are to truly have effective pension reform legislation.

First, it is fundamental to provide the American worker not only with the capability, but the right to appeal through the Secretary into the Courts any time he feels his rights have been violated. Although H.R. 2 and H.R. 4200 recently passed by the Senate does provide for administrative review, the Secretary should be empowered to "go to bat" for a plan participant. Accordingly, Congress and the Ways and Means Committee should consider Section 512 of H.R. 9999 which clearly defines the providing of legal assistance to plan participants.

Second, it is essential that to avoid administrative confusion that we centralize the responsibility for carrying out any pension reform legislation enacted in one agency. H.R. 9999 establishes a Pension Security Administration which would oversee the operation of every aspect of pension reform including vesting, funding, reporting and reinsurance. Whether or not responsibility is eventually lodged in the Department of Labor or the Department of the Treasury, administrative responsibility should be reserved for one agency, so that the working American will have to deal with on e agency, not two, or three, or four.

Third, even given the above reform areas substantial procedural problems will remain to be worked out in the years ahead. Even with the passage of H.R. 2 and companion

legislation from the House Ways and Means Committee no clear mechanism currently exists through which sufficient data and information can be channeled to the Congress to enable us to insure an effective and functional program. H.R. 9999 establishes a Bureau of Pension Statistics designed to keep careful tabs on the problems we encounter down the road after passage of a pension reform law. This is a full-time job and must be done separate of any operating agency. Accordingly, Congress should move to include such a Bureau in any legislation considered.

Fourth, the issue of "portability" should be considered. While it should be recognized that any attempt to make vested funds portable from one plan to another is impracticable and administratively unfeasible, it is possible, and indeed, imperative, that we provide for a system through which an individual may accrue vested funds from several plans throughout his work life-time. It is therefore imperative that Congress carefully consider a means to expedite portability in this matter.

In sum, these are some of the areas which should be addressed in addition to the provisions of H.R. 2. Hopefully, Congress will move to enact legislation including these concepts before the end of the session.

MARVIN L. ESCH, Member of Congress.